Application for Certified Clinical Anxiety Treatment Professional (CCATP)

Date: _____

Name (as it appears on your license, registration, credential or membership):

_____

Street Address:_____

City: _____ State/Territory:_____

Postal Code: _____ Country:_____

Phone: _____

Email Address:_____

I attest to the following (please initial each):

____I am a licensed, registered, credential or membered professional as outlined in Criterion 1.1 of the Certification Standards

____My professional license, registration, credential or membership is current and in good standing as outlined in Evergreen Certifications' Code of Ethics

____I have completed the required 12 education hours as outlined in Criterion 2.1 of the Certification Standards

____I have conducted a minimum of 200 clinical contact hours with Anxiety-diagnosed clients, with the use of weekly consultation and/or supervision as outlined in Criterion 3.0 of the Certification Standards

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted.

I understand that information submitted with this application may be verified for accuracy by Evergreen Certifications. I also agree to contact Evergreen Certifications in the event that I no longer meet the requirements to be a Certified Clinical Anxiety Treatment Provider.

Signed: _____ Date: _____