

Application for Membership and Board Certification

Spiritual Mental Health Professional

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| **Applicant Information**  Check here \_\_\_\_if you request your name and contact information be kept confidential and limited to only WSHO leaders | | | | |
| Name (Last, First, MI):  Nickname:  Gender: | | | | Marital Status:  Birthdate:  Race: |
| Street/Mailing Address:  E-mail Address: | | | | Home Phone:  Mobile Phone: |
| **Denomination/Faith Group Information** | | | | |
| Name of Faith Tradition/Religion (Catholic, Buddhist, Jewish, etc.) | | Name of your local Church Congregation, Presbytery, Diocese, Conference, Association, Synod, Ward, Temple: | | |
| Are You Ordained\_\_\_ Commissioned\_\_\_ Consecration \_\_\_  Date of Ordination/Commissioning/Consecration: \_\_\_\_\_\_\_\_\_\_\_\_ | | Are you an appointed spiritual/religious lay-leader in your faith tradition/church? Yes\_\_\_ No \_\_\_  Describe the nature of your duties as a lay-leader: | | |
| **(If you are a member of a local professional WSHO Chapter complete the following)** | | | | |
| Name of Sponsoring WSHO Chapter: | City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Prov:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Name of Chapter President: | Mobile #:  Email: | | | |
| **Education**  **(attach notarized copies of diplomas)** | | | **Name of Degree Program and Graduation Year** | |
| Bachelor’s Degree:  Name of University:  Location: | | |  | |
| Master’s Degree:  Name of University/Seminary:  Location: | | |  | |
| PhD/DMIN/PSYD/EdD/MD/JD:  Name of University/Seminary:  Location: | | |  | |
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**Clinical Pastoral Education (CPE) (preferred but not required)**

Have you successfully completed any quarters of CLINICAL PASTORAL EDUCATION (CPE)? Yes \_\_\_ No\_\_\_ N/A\_\_\_

If “yes”, Number of Units: \_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of CPE Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must attach a copy of CPE supervisor’s evaluation for each unit of CPE successfully completed.

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| **PROFESSIONAL MEMBERSHIPS, ASSOCIATIONS & AFFILIATIONS START DATE** | | |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

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| **CLINICAL COUNSELING EXPERIENCE AND SUPERVISION** |
| **WSHO STANDARD**   * 2100 HOURS POST GRADUATE CLINICAL COUNSELING/THERAPY EXPERIENCE * 130 HOURS OF CLINICAL SUPERVISION RECEIVED * ON-GOING PEER REVIEW/MENTORING   WSHO Certification and annual re-certification requires ongoing clinical peer supervision (one-on-one and/or peer group format) of clinical work. List the name and contact information for your current peer/mentor/supervisor who can verify your ongoing clinical peer supervision.  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Degree: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to you: Peer (individual)\_\_\_ Peer Group\_\_\_ Mentor\_\_\_ Supervisor\_\_\_ Other \_\_\_ |

**CURRENT PROFESSIONAL COUNSELING/THERAPY POSITION AND RESPONSIBILITIES**

Name of institution/center or church: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of your work responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of years you have been a professional counselor/ psychotherapist: \_\_\_\_\_\_\_\_\_\_

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| **LICENSURE & CERTIFICATION** |
| WSHO STANDARD: Professional licensure is preferred but not required for Spiritual Mental Health Professional credential  Do you have a professional license to practice counseling/psychotherapy: Yes:\_\_\_ No:\_\_\_  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Awarding Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have professional malpractice insurance coverage: Yes:\_\_\_ No:\_\_\_ Note/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If you have a certification credential from another professional, i.e. APA, AAMF, etc, organization, please complete the following:  Name of professional certifying organization where you received your credential: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of credential received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date credential awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Provide a notarized copy of both your license and certification) |

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| **Required Supporting Documents** |
| * Education: Copies of University/Seminary diplomas * CPE: If you have taken clinical pastoral education (CPE), provide copy of supervisor’s Final Evaluation * WSHO Ecclesiastical Verification Form from Religious/Spiritual Endorsing/Commissioning Authority (preferred) * Current copy of your resume * Copy of WSHO Professional Honor Code Agreement * Ability and willingness to prudently and appropriately make and incorporate a ‘spiritual diagnosis’ into clinical practice * Provide (3) Character References/Letters of Recommendation. (2) letters from peers and (1) from your administrator /CEO that is written, signed, and dated on official letterhead paper of the recommending organization * Write a statement about what you consider constitutes: 1) Spiritual Health; 2). Emotional Wellness; 3) Love; and 4). Effective counseling to a diverse spiritual, religious, and multicultural clientele * Write a 1–2-page essay presenting your view and experience regarding the integration of spiritually and psychology * Write an essay (1 page or less) regarding the integration of personal character and professional competence in mental health counseling/therapy * Write a 1 page essay describing how you personally and professionally live the WSHO Mission Statement: (Spirituality: Where it is alive, sustain it; Where it is dormant, revive it; Where it is absent, invite it) * Provide documented evidence of 2100 post-graduate clinical hours of counseling/therapy experience * Write a 2-3 page religious/spiritual autobiography describing your spiritual journey in life |

Describe your reason(s) for seeking WSHO board certification at this time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CERTIFICATE** |
| Print your name as you want it to appear on your certificate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Level of Certification Requested**

**(choose one)**

\_\_\_Associate Board Certified Spiritual Mental Health Professional (Bachelor’s Degree)

\_\_\_Board Certified Spiritual Mental Health Professional (Master’s Degree and higher)

\_\_\_Master Board Certified Spiritual Mental Health Professional (Master’s Degree and higher)

Note: WSHO Standard for *Master Board Certification* requires applicant to provide written documentation substantiating the following:

(1. Minimum of seven years of continuous post-graduate professional clinical experience as a mental health professional

(2. Demonstrated *leadership and professional achievement* in three of the following areas:

Clinical practice\_\_ Teaching\_\_ Publication\_\_ Research\_\_ Contribution to society/church\_\_ Clinical Supervision\_\_ Other\_\_

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***SPECIALIZED CLINICAL/MINISTRY DESIGNATOR***

If you seek a specialty credential to be added to your certification in any of the following specialties, you must also attach proof of a minimum of two years specialty experience per designator, and include a letter of verification/recommendation from your administrator/supervisor. A $20.00 fee will be assessed per specialty.

\_\_\_HEALTHCARE (HOSPITAL, HOSPICE, PRIVATE PRACTICE, ETC.)

\_\_\_ADDICTION RECOVERY

\_\_\_SCHOOL/CAMPUS COUNSELING

\_\_\_GRIEF & BEREAVEMENT

\_\_\_MILITARY

\_\_\_PRISON/CORRECTIONS

\_\_\_GROUPS

\_\_\_BUSINESS AND CORPORATE

\_\_\_VETERANS SERVICE GROUPS (VFW, DAV, AL)

\_\_\_LAW ENFORCEMENT/POLICE/FBI/BORDER PATROL

\_\_\_DISASTER RESPONSE

\_\_\_CHURCH/PARISH COUNSELING

\_\_\_OTHER (explain)

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| **Application Fees**  Scan and attach completed application and required supporting documents, and email to: [wshopresident@gmail.com](mailto:wshopresident@gmail.com). Application fee can be paid online at [www.wshochaplaincy.org](http://www.wsho.info) under “Make a Payment,” or by check to: WSHO, P.O. Box #710096, Salt Lake City, Utah, 84171, or via Venmo: @Mark-Allison-47 |
| Choose all which apply:    Application Fee (non-refundable): \_\_\_ $50.00  Certification Fee (non-refundable): \_\_\_ $225.00 Associate Board Certified Spiritual Mental Health Professional) (ABCSP)  \*choose one (Bachelor’s Degree and higher)  \_\_\_ $250.00 Board Certified Spiritual Mental Health Professional (BCSP)  (Master’s Degree and higher)  \_\_\_ $300.00 Master Board Certified Spiritual Mental Health Professional (MBCSP)  (Master’s Degree and higher)  Specialized Ministry Designator(s): \_\_\_ $20.00 per Designator x \_\_\_  (non-refundable)  Total Due: $\_\_\_\_\_.00 |

\_\_\_ Check here only if you prefer your credential be called: *Pastoral Psychotherapist/Counselor* rather than Spiritual Mental Health Professional

Have you ever been convicted of a crime and/or expelled by a professional organization? Yes\_\_\_ No \_\_

If “yes”, describe the issue and action(s) taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I verify the information I have provided in this application to be completely true, accurate, and current.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

WSHO office use only:

\_\_ Background Check \_\_ Interview

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