American Association of Indigenous
Clinical Pastoral Supervision & Psychotherapy, Inc.
142 05 Roosevelt Avenue, Apt. 731 Flushing, NY 11354, USA.
www.aaicpsp.org   AAICPSP@gmail.com

APPLICATION FORM
for Grandfathering of Credential with AAICPSP

CATEGORY OF MEMBERSHIP:
Mark appropriate category with an ✗
If unable to mark with an ✗, then enter the category here: _____

- ☐ DIPLOMATE (PSYCHOTHERAPY)
- ☐ DIPLOMATE (CLINICAL SUPERVISION)
- ☐ CLINICAL COUNSELOR
- ☐ CLINICAL PASTORAL CARE
- ☐ CLINICALLY TRAINED CLERGY
- ☐ PSYCHIATRIST
- ☐ PSYCHOLOGIST
- ☐ SCHOOL COUNSELOR
- ☐ CHAPLAIN
- ☐ MARRIAGE COUNSELOR
- ☐ FAMILY COUNSELOR
- ☐ SUBSTANCE ABUSE REHABILITATION COUNSELOR
- ☐ MENTAL HEALTH COUNSELOR
- ☐ REGULAR MEMBER
- ☐ HONORARY MEMBER

NAME		IDENTITY CARD NO. OR PASSPORT NO.
(Surname)	(First/Given Name)	

HOME ADDRESS			
(Street)	(City/Town)	(State)	(Country)

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			
(Street)	(City/Town)	(State)	(Country)

CONTACT

Work Phone:	Mobile Phone:	Fax:	Home Phone:	Email:

EDUCATION (BEGINNING WITH SECONDARY SCHOOL ONWARDS)

Name of School	Location	Year (From / To)
1.		
2.		
3.		
4.		
5.		
6.		

CLINICAL TRAINING

Name of School	Location	Year (From / To)
1.		
2.		
3.		
4.		
5.		
6.		

PROFESSIONAL EXPERIENCE

Name of Company/Organization/Agency (beginning with the present)	Job Title	Location	Year (From / To)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

CURRENT AND PRIOR CREDENTIALS, CERTIFICATIONS & LICENSES

Name of Professional Organization / Licensing Body	Credential / License Title	Period (From / To)
1.		
2.		
3.		
4.		
5.		
6.		

REFERENCES

PROFESSIONAL

Name	Address	Phone

PERSONAL

Name	Address	Phone

OTHER INFORMATION YOU WISH TO SHARE OR SUBMIT