



AMERICAN ASSOCIATION OF COUPLES AND SEX THERAPISTS

APPLICATION FOR AACAST CERTIFICATION COUPLES AND SEX THERAPIST

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ ALTERNATE TELE: _____ FAX: _____

EMAIL: _____ WEB SITE: _____

ACADEMIC DEGREES:

<i>DEGREE</i>	<i>FIELD</i>	<i>INSTITUTION</i>	<i>YEAR AWARDED</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PROFESSIONAL EXPERIENCE HISTORY (most recent first):

I HAVE COMPLETED THE FOLLOWING CERTIFICATION REQUIREMENTS:

- Attended the entire year long Couples and Sex Therapy Training Program, which includes Inter-Analytic Couples Therapy courses and the Human Sexuality, Sex Education and Sex Therapy Course twice.
- Attended the entire Advanced Couples and Sex Therapy Seminar
- Presented three cases in supervision to demonstrate training, skills and knowledge
- I am a member in good standing of AACAST
- I have read and agree to abide by the AACAST Code of Ethics. By signing the application for certification form, I agree to be bound by the AACAST Code of Ethics.
- I have attached a copy of a valid state license in at least one of the following fields: marriage and family therapy, psychology, social work, counseling, medicine, or nursing.

I waive any claim to confidentiality of the material stated herein. Further, I agree that I am submitting this application voluntarily and indemnify and hold harmless AACAST or any of its directors, officers, members or agents.

Signature of Applicant

Print Name

Date

PLEASE COMPLETE AND SIGN THE APPLICATION, AND ATTACH A COPY OF A VALID LICENSE FROM YOUR LICENSING BOARD.
PLEASE ENCLOSE A CHECK IN THE AMOUNT OF \$100.00 USD FOR THE NON-REFUNDABLE APPLICATION FEE.
MAIL TO: AACAST, 1072 KATHERINE RD., SANTA SUSANA, CA 93063
ANY QUESTIONS MAY DIRECTED TO WENDY AT 818-540-8657 OR WENDY@AACAST.NET