

DOWAMA Consortium of Professional Counselors

CENSUS & AFFIDAVIT

(Please print legibly)

First Name _____ Last Name _____

I would like to register in the Diocese of Wichita and Mid America (DOWAMA) as a professional counselor and resource person and possibly be listed in a referral Directory in one of the following disciplines:

<i>Psychiatrist</i> MD Board of Psychiatry MD License# _____ State ____ Expiration ____/____/____ Board Website _____	<i>Clinical Psychologist</i> PhD License# _____ State ____ Expiration ____/____/____ Board Website _____	<i>Marriage & Family Therapist</i> MA/MS L(C)MFT License # _____ State ____ Expiration ____/____/____ Board Website _____
<i>Professional Counselor</i> (misc) MA/MS License # _____ State ____ Expiration ____/____/____ Board Website _____	<i>Clinical Social Worker</i> MSW License # _____ State ____ Expiration ____/____/____ Board Website _____	<i>Licensed Chemical Dependency Counselor</i> LCDC # _____ State ____ Expiration ____/____/____ Board Website _____

- I am the holder of a Masters/Doctoral degree in a counseling field from an accredited university.
 University _____ Degree Granted _____ Year _____
- I can practice counseling in my field independently of supervision and have logged at least 3000 clinical hours under supervision and have been in practice for a minimum of five (5) years
- I agree to notify the DOWAMA Consortium of Professional Counselors if I cease to be licensed in my particular field.
- I carry malpractice insurance with limits of at least 1,000,000.00 per occurrence and \$3,000,000.00 in the aggregate and I agree to notify the Consortium if I cease having insurance.
- I agree to indemnify and hold the DOWAMA harmless should they be named as a defendant in a lawsuit.
- I attest to the fact that I have never been the subject of any investigation of allegations of inappropriate conduct of a moral, ethical or sexual nature brought by a patient or client of mine.
- I agree to notify the DOWAMA if I become the subject of an investigation of allegations of inappropriate conduct of a moral, ethical or sexual nature brought.
- I believe the above information to be true and I agree to notify the DOWAMA Consortium promptly should any of the submitted information about me change.

- I am a member in good standing of the Orthodox Church as attested to by the signature below of my Parish Priest.

Priest's Name _____ Signature _____ Date ____/____/____

I understand that the following information may be listed PUBLICALLY in a referral directory.

Title _____ First Name _____ Last Name _____

Discipline (choose one based on license): Psychiatry Psychology Marriage and Family Therapy

General Counseling Social Work Chemical Dependency

Address _____ State _____ Zip _____ Telephone _____

Email _____ Website _____

Specialization _____

Signature _____ Date ____/____/____

Please remit via Post to "DOWAMA Consortium of Professional Counselors" at 414 Wayside Dr, San Antonio, TX 78213