Certification for the FSAP

Please fill in the following information and provide two letters of recommendation from therapists who feel ethically comfortable referring patients to you for FSAP therapy.

Name: _____ Tel: _____

Address: _____

City: _____

License type: _____

Email address: _____

Dates of 2-day FSAP workshop:_____

Name of group consultant: _____

Signature of group consultant: _____

Dates of group consultation (8 required):

_____

Name of individual consultant: _____

Signature of individual consultant: _____

Dates of individual consultation (4 required):

_____

I, _____,affirm that I have performed at least 40 hours of FSAP therapy with at least 10 clients.

_____ Date: _____

(Your signature)