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:

DEGREE *FIELD* *INSTITUTION* *YEAR AWARDED*

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_____

_____

PROFESSIONAL EXPERIENCE HISTORY (most recent first):

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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
- ☐ Attended the entire Advanced Couples and Sex Therapy Seminar
- ☐ Presented three cases in supervision to demonstrate training, skills and knowledge
- ☐ Passed the oral exam 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