



Certificate Program Registration Form

Loss and Traumatic Stress, Child Sexual Abuse Treatment & Early Childhood Mental Health

Cultivating Ideas

Last Name: _____ Credentials (PhD, PsyD, MSW, etc.) _____

First Name: _____ Preferred Title (Dr., Ms., etc.): _____

Educational Institution _____ Field _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

e-mail: _____

Tel: _____ Home Cell Office Tel: _____ Home Cell Office

Select one of the following Certificate Program options: (Please mail or fax your form to the Post Graduate Center, Institute for Graduate Clinical Psychology, Widener University, One University Place, Chester, PA 19013-5792, f: 610-499-4625).

Childhood Sexual Abuse Certificate Yes No

I have a Masters degree

Start Date: _____
(Date of first workshop)

Note: Registrants must complete this program within 12 to 24 months from the start date listed above.

Loss and Traumatic Stress Certificate Program Yes No

I have a Masters degree

I have a professional license that is in good standing: License # _____ Expires _____
(a copy of your professional license must accompany this form)

Start Date: _____
(Date of first workshop)

Note: Registrants must complete this program within 15 to 36 months from the start date listed above.

Early Childhood Mental Health Certificate Program Yes No

Enrollment Year _____ Job Title _____

Agency _____

Brief Description of Job Duties and Population Served:

CE Credits needed in what field (Underline your choice): Psychology; Social Work; Nursing; MFT; LPC

Note: The enrollment deadline is July 1st of each year.