

# APPLICATION FOR INTERNSHIP OR A STAFF POSITION

## BIBLICAL COUNSELING CENTER

825 4<sup>th</sup> Street West Ste. 1-B  
Palmetto, FL 34221

PLEASE TYPE OR PRINT IN BLACK INK

DATE: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Divorced  Widowed  Separated SPOUSES' NAME: \_\_\_\_\_

CHURCH: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PASTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

### EDUCATION:

<i>Institution</i>	<i>Degree</i>	<i>Date</i>	<i>Address</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### REFERENCES OF ENDORSEMENT.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**TESTIMONY OF SALVATION:**

**MINISTRY / COUNSELING EXPERIENCE:**

**REASON FOR APPLYING:**



**LIST AT LEAST TWO AREAS OF SPECIALIZATION:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE:** (INCLUDE COPY OF SHEET VERIFYING THE FOLLOWING INFORMATION.)

POLICY NUMBER: \_\_\_\_\_  
INSURANCE CARRIER: \_\_\_\_\_  
AMOUNT OF COVERAGE PER OCCURRENCE: \_\_\_\_\_

**STATE LICENSURE:** (INCLUDE A COPY VERIFYING THE FOLLOWING INFORMATION)

LICENSE / CERTIFICATE NUMBER: \_\_\_\_\_  
STATE OF ISSUE: \_\_\_\_\_  
EFFECTIVE DATE: \_\_\_\_\_  
EXPIRATION DATE: \_\_\_\_\_

**AVAILABILITY:**

- CAN ACCOMMODATE EMERGENCY SESSIONS
- NON-EMERGENCY INITIAL SESSIONS WITHIN THREE DAYS
- LATE AFTERNOON APPOINTMENTS AVAILABLE
- EVENING APPOINTMENTS AVAILABLE
- WEEKEND APPOINTMENTS AVAILABLE AS NEEDED

**LANGUAGES SPOKEN:** \_\_\_\_\_

**PLEASE MARK  THE APPROPRIATE BOX IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES". ATTACH AN EXPLANATION SHEET GIVING THE RELEVANT DETAIL.**

- HAVE YOU EVER BEEN CHARGED OR CONVICTED OF A FELONY IN ANY STATE?
- HAVE YOU EVER BEEN CITED FOR VIOLATION OF ETHICAL STANDARDS BY A PROFESSIONAL ORGANIZATION?
- HAVE YOU EVER HAD YOUR LICENSE REVOKED OF SUSPENDED IN ANY STATE?
- DO YOU HAVE ANY PAST OR PENDING LEGAL ACTIONS AGAINST YOU RELATED TO YOUR CLINICAL PRACTICE?
- HAVE YOU EVER HAD YOUR MALPRACTICE INSURANCE CANCELED?
- HAVE YOU EVER BEEN ACCUSED OF SEXUAL HARASSMENT OR ASSAULT?
- HAS ANY CLAIM OR SUIT BEEN BROUGHT AGAINST YOU DUE TO ALLEGED MALPRACTICE?
- HAVE YOU EVER HAD YOUR HOSPITAL PRIVILEGES REVOKED?
- FOR PSYCHIATRISTS, HAVE YOU EVER HAD YOUR DEA NUMBER REVOKED?
- HAVE YOU EVER BEEN DISCIPLINED BY A CHURCH, DEFROCKED, OR PLACED ON ECCLESIASTICAL PROBATION?

**PLEASE MARK  THE APPROPRIATE BOX NEXT TO THE AREAS IN WHICH YOU ARE QUALIFIED TO COUNSEL PEOPLE.**

- |  |  |
|--|--|
| <input type="checkbox"/> SEXUAL ABUSE                  | <input type="checkbox"/> ABORTION                                    |
| <input type="checkbox"/> SINGLE PARENT ISSUES          | <input type="checkbox"/> WOMEN'S ISSUES                              |
| <input type="checkbox"/> EATING DISORDERS              | <input type="checkbox"/> MEN'S ISSUES                                |
| <input type="checkbox"/> CAREER ISSUES                 | <input type="checkbox"/> HOMOSEXUAL & TRANSGENDER ISSUES             |
| <input type="checkbox"/> DEATH / GRIEF                 | <input type="checkbox"/> ANXIETY DISORDERS                           |
| <input type="checkbox"/> WEIGHT PROBLEMS               | <input type="checkbox"/> BIPOLAR DISORDER                            |
| <input type="checkbox"/> SEXUAL DYSFUNCTION            | <input type="checkbox"/> BORDERLINE PERSONALITY DISORDER             |
| <input type="checkbox"/> DOMESTIC VIOLENCE             | <input type="checkbox"/> PERSONALITY DISORDERS                       |
| <input type="checkbox"/> OBSESSIVE COMPULSIVE DISORDER | <input type="checkbox"/> ADULT CHILDREN OF ALCOHOLICS ISSUES         |
| <input type="checkbox"/> SEXUAL ADDICTION              | <input type="checkbox"/> CHRONICALLY MENTALLY ILL (AXIS I DIAGNOSES) |
| <input type="checkbox"/> SUBSTANCE ADDICTION           | <input type="checkbox"/> _____                                       |
| <input type="checkbox"/> GERIATRICS                    | <input type="checkbox"/> _____                                       |
|  | <input type="checkbox"/> _____                                       |

**PLEASE SUMMARIZE THE CLIENT FOLLOW-UP PROCEDURES THAT YOU PRACTICE.**

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**PLEASE LIST NAMES AND PROVIDE THE ADDRESSES AND PHONE NUMBERS OF TWO REFERENCES WHO ARE QUALIFIED TO COMMENT ON THE PROFESSIONAL, CLINICAL AND / OR PASTORAL EFFECTIVENESS OF YOUR PROGRAM / PRACTICE.**

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I CERTIFY THAT THE INFORMATION THAT I HAVE PROVIDED ABOUT ME OR THE CLINICAL ORGANIZATION I REPRESENT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT, IF I HAVE OMITTED DAMAGING INFORMATION OR MISREPRESENTED ANY FACTS THE BIBLICAL COUNSELING CENTER MAY CANCEL ANY CONTRACT OR ARRANGEMENT IN FORCE AT THE TIME.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

ORGANIZATIONAL TITLE: \_\_\_\_\_  
(IF APPROPRIATE )

**FOR OFFICE USE ONLY**

DATE OF APPROVAL / REJECTION: \_\_\_\_\_ EVALUATOR: \_\_\_\_\_

REASON(S) FOR REJECTION: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*PLEASE RETURN OR FAX THIS APPLICATION TO:*

**BIBLICAL COUNSELING CENTER**  
**Suite 1-B 825 4<sup>th</sup> Street West Palmetto, FL 34221**

Office Phone & Fax: 941-729-6600  
TRUTHtransforms@aol.com