Mission Kids
Child Advocacy Center

Name: _____

Organization Name (if applicable):_____

Address: _____

County: _____

E-mail: _____

Phone Number: _____

1. Are you licensed? (preferred but not required)_____
   If YES, what type of license? (LPC, LCSW, LMFT, etc.)_____
2. Do you have a master's degree in a clinical field? _____
   If YES, what type of degree?_____
3. Do you currently provide psychotherapy? _____
   If YES, what level of care (out-patient, family-based, residential, etc.)
   _____
4. Do you currently work with children and adolescents? _____
5. Do you currently collaborate with a Child Advocacy Center? **YES** **NO**
   If yes, please provide the name: _____
6. Would you be willing and interested in collaborating with a Child Advocacy Center? _____
7. Do you currently provide therapy to child sexual abuse victims? **YES** **NO**
8. Do you currently have a clinical supervisor? **YES** **NO**
9. Is your supervisor currently trained in TF-CBT? (preferred but not required)
   YES **NO**

10. Is your supervisor also applying for this TF-CBT project? _____
    If YES, please provide the name of the supervisor
    _____

If you have any questions, please feel free to contact Madeline Mitchell at 484-687-2990 ext. 1013 mmitchell@missionkidscac.org.