Application for Certification As a Sex Therapist

Instructions:
Complete this application using the following checklist. When all information is collected mail it to:

American Board of Christian Sex Therapists
1325 Satellite Blvd NW, Suite 1502
Suwanee, GA 30024

Two (2) copies of each of the following:	
☐ Completed application form. ☐ Personal Theology of Sex paper. ☐ Supporting documentation for coursework. ☐ Appendix D & E if applicable. ☐ Copy of your license(s). ☐ Official abstract from <u>each</u> graduate or specialization program attended.	☐ Supervisor report from each supervisor listed. ☐ Professional reference from each supervisor listed. ☐ Faith and character reference(s). ☐ Application fee of $200.00 made out to ABCST.

We are glad you are applying and are looking forward to you joining our team.
~ American Board of Christian Sex Therapists

Application for Certification

American Board of Christian Sex Therapists
1325 Satellite Blvd NW, Suite 1502
Suwanee, GA 30024

CONTACT INFORMATION – Public

Note: This is public information used in our member directory so potential clients can find you.

Name: _____

Practice Name: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

URL: _____

E-mail address: _____

CONTACT INFORMATION – Private

Note: This contact information is only available in our office. Include whatever you wish us to have.

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other phone: _____

URL: _____

E-mail address: _____

Which address would you like us to use as your main mailing address (where do you want to receive mail from ABCST)? ☐ **Office** ☐ **Home**

DEMOGRAPHIC INFORMATION

Note: ABCST does not discriminate nor evaluate your application based on this information. We do, however, track this information for internal research. You may choose not to answer these questions.

Birthdate: ____/____/____ Sex: ☐ Male ☐ Female Denominational affiliation: _____

Race: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Name: _____

EDUCATION

Undergraduate

School	Degree	Area of Study (Major)	Year

Graduate (You must request that each graduate school you attended send us 1 official transcript.)

School	Degree	Area of Study (Major)	Year

Post-Graduate/Specialization Program
(You must request that 1 official transcript from each of these programs be sent to us.)

School	Degree	Area of Study (Major)	Year

WORK HISTORY (professional)

☐ **Mark if additional work history is included in Appendix D**

Where	Position	From	To
Responsibilities …… ……			

Where	Position	From	To
Responsibilities …… ……			

Where	Position	From	To
Responsibilities …… ……			

Where	Position	From	To
Responsibilities …… ……			

Where	Position	From	To
Responsibilities …… ……			

Name: ________________________________

PROFESSIONAL STANDING

Applicants for certification with ABCST must already be established professionals in a therapy related profession (i.e., Psychologist, Marriage and Family Therapist, Social Worker, Professional Counselor, Mental Health Counselor, Psychiatrist, Physician, Clinical Nurse Practitioner). Use this page and other documentation needed to support your professional standing.

PROFESSIONAL AFFILIATIONS

List professional organizations you are a member of (i.e., APA, ACA, AAMFT, etc.)

Group	Type of Membership (Clinical, Affiliate, etc.)
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No
Does this group have a code of ethics? ☐ Yes ☐ No	Do you abide by it? ☐ Yes ☐ No

CERTIFICATION – List only therapy related certifications.

Certification Body	Certification	Year Given	Year Expires	Number

LICENSURE – ■ Mark if your state does not have a therapy license and complete Appendix A.

If your state offers licensure you must hold a valid license for full certification.
You must include a copy of your current license(s) with your application packet.

License (i.e. LMFT, LPC, LMHC, Psychologist)	State	Year Given	Year Expires	Number

Have you ever been disciplined, refused admission, or removed from membership or affiliation with any professional organization, certification group, or licensing board? ☐ Yes ☐ No

Have you ever been sued professionally? ☐ Yes ☐ No

If yes, please explain on a separate sheet.

Name: _____

SEX THERAPY TRAINING

Verification of 150 hours

Applicants for certification must document at least 150 hours of training in sex therapy. This training must be professional in nature and provided by recognized clinicians or clinical groups. It is the applicant's responsibility to document a professional level of training. Graduate level training programs qualify with little supporting documentation. If you are submitting workshop or conference hours, please include a copy of the abstract and learning objectives from each workshop.

Documenting Sex Therapy Training can be bypassed if you qualify for one of the following:

- ☐ I completed the full Institute for Sexual Wholeness program (intro, 3 intermediate courses, and at least one advanced course). If you check this box, please request a transcript from Richmont Graduate University showing coursework and skip to page 9.
- ☐ I am currently certified as a sex therapist by the American Association of Sex Educators, Counselors and Therapists (AASECT). Please send a copy of your active certification, complete subject content part 1 (page 6) but skip part 2.
- ☐ I am currently a Board Certified Diplomate of The American Board of Sexology (Counts for 120 hours. An additional 30 hours after certification date must be documented below.)
- ☐ I have completed a specialized program in Sex Therapy other than the Institute for Sexual Wholeness program that included at least 150 hours of classroom instruction. (You must include a transcript from the program with your application.)

  Identify program completed:

  _____

  _____

Instructions: Provide the following information for each course you are requesting count toward your certification.

Course title: The name of the specific course, workshop or training session you attended.
Hours: The number of hours you were in training with this course.
Instructor: The name of the professor, workshop presenter or course leader.
Organization: What organization sponsored the event (i.e., AASECT, AACC, local organization)
Type of training: Identify if this is a graduate course, breakout session at a conference, etc.

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Total hours for this page: ____

Name: ______________________________

Note: Make as many copies of this page as necessary.

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Page ___ of ____ pages for this form.

Total hours for this page:

Name: ______________________________

Verification of subject content

Applicants for certification must document they have training in each of the required subjects. This training must be professional in nature and provided by recognized clinicians or clinical groups. It is the applicant's responsibility to document a professional level of training. Graduate level training programs qualify with little supporting documentation. If you are submitting workshop or conference hours please include a copy of the abstract and learning objectives for the workshop (2 copies).

Verification of subject content occurs in 2 steps – Theology Integration and Standard Sex Therapy topics

Part 1 – Integration of Theology and Sex Therapy

Applicants must document at least 10 hours of courses where the focus is on integration of sex and theology (i.e., breakout sessions on sex therapy at CAPS or AACC conferences typically qualify) Documentation of this section can be bypassed for those who can check the following:

☐ I have taken one or more courses from the Institute for Sexual Wholeness

Identify course and semester: ______________________________

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

Course title:			Hours:
Instructor:	Organization	Type of Training:	

☐ Mark if additional pages are included for this section. **Total hours for this page:** ☐

Name: _____

Part 2 – Sex Therapy Topics

Applicants must document they have received education in all of the required subject areas. Documentation of this section can be bypassed for those who completed the Institute for Sexual Wholeness program or are already certified by AASECT or ABS.

Note: If the course title doesn't immediately suggest the subject area was covered be sure to include a copy of the syllabus. For conferences/workshops, include a copy of the abstract, learning objectives or other documentation of the subject covered.

Sexual and reproductive anatomy and physiology.

Course title:		
Instructor:	Organization	Type of Training:

Developmental sexuality (across the life-span).

Course title:		
Instructor:	Organization	Type of Training:

Gender and gender identity issues.

Course title:		
Instructor:	Organization	Type of Training:

Socio-cultural factors in sexual values and norms.

Course title:		
Instructor:	Organization	Type of Training:

Medical aspects of sexuality and sexual function (illness, disability, drugs, pregnancy, STD's).

Course title:		
Instructor:	Organization	Type of Training:

Sex research

Course title:		
Instructor:	Organization	Type of Training:

Diagnosis and treatment of sex offenders and sexual abuse.

Course title:		
Instructor:	Organization	Type of Training:

Name: _____

Diagnosis of sexual disorders/dysfunctions.

Course title:		
Instructor:	Organization	Type of Training:

Treatment of sexual disorders/dysfunctions from various theories of therapy.

Course title:		
Instructor:	Organization	Type of Training:

Assessment and treatment of Paraphilias.

Course title:		
Instructor:	Organization	Type of Training:

Assessment and treatment of Sexual compulsivity (sex addiction).

Course title:		
Instructor:	Organization	Type of Training:

Theory and methods of intervention in relationship systems experiencing sexual problems.

Course title:		
Instructor:	Organization	Type of Training:

Ethical and legal aspects and issues in Sex Counseling.

Course title:		
Instructor:	Organization	Type of Training:

Consultation, collaboration and referral in sex counseling.

Course title:		
Instructor:	Organization	Type of Training:

Issues of aging in sexual relationships.

Course title:		
Instructor:	Organization	Type of Training:

Name: _____

VERIFICATION OF EXPERIENCE

Applicants for certification must document they have completed at least 200 hours of face to face sex therapy with clients and at least 50 hours of supervision for these sex therapy cases. Other requirements are listed below.

Within sex therapy most therapists will focus their practice, by design or default, on specific issues. It is not expected that you have experience and expertise in all sex therapy issues. Certification, however, is broad and it is expected that the sex therapy professional have experience in a number of issues. Please identify below the level of experience and competence you feel in the sexual issues listed.

Rank your **experience** on the following scale.	Rank your **Competence** on the following scale.
⓪ – I have no experience in therapy with this issue. ① – I have worked with this issue in a couple cases. ② – I work with this issue occasionally in therapy. ③ – I work with this issue often in therapy ④ – Work with this issue in most cases in my practice	⓪ – It would be unethical for me to work with this issue ① – I feel able to work with this issue when necessary but am not very confident ② – I have the basic skills and confidence needed to work with this issue in my practice ③ – I work comfortably with this issue and clients improve under my care. ④ –I am very skilled and knowledgeable in this issue

	Experience	Competence
Hypoactive Sexual Desire Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Aversion Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Female Sexual Arousal Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Male Erectile Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Female Orgasmic Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Male Orgasmic Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Premature Ejaculation	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Dyspareunia	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Vaginismus	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Masochism	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Sadism	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Voyeurism	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Exhibitionism	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Fetishism	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Other Paraphillias	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Gender Identity Disorder	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Abuse recovery	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Perpetrators	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Sexual Addiction	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Incest	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Homosexuality	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Adolescent Sex Offenders	⓪ ① ② ③ ④	⓪ ① ② ③ ④
Adult Sex Offenders	⓪ ① ② ③ ④	⓪ ① ② ③ ④
	⓪ ① ② ③ ④	⓪ ① ② ③ ④
	⓪ ① ② ③ ④	⓪ ① ② ③ ④

Name: ______________________________

Verification of 200 hours of supervised sex therapy

Applicants must document they have met the required 200 hours of supervised sex therapy. Each hour counted must be therapy with a client where the primary focus of the therapy is a sexual issue. No more than 25% of the total can be group therapy. Attach additional sheets if necessary. Didactic presentations do not qualify as sex therapy.

Place of service:		Hours of sex therapy at this location:
Position:	Dates of Service:	
Sex therapy issues seen at this location:		
Type of sex therapy at this location (in hours): ____ Couples ____ Individual Adult Males ____ Individual Adult Females ____ Group (Males) ____ Group (Females) ____ Minors		

Place of service:		Hours of sex therapy at this location:
Position:	Dates of Service:	
Sex therapy issues seen at this location:		
Type of sex therapy at this location (in hours): ____ Couples ____ Individual Adult Males ____ Individual Adult Females ____ Group (Males) ____ Group (Females) ____ Minors		

Place of service:		Hours of sex therapy at this location:
Position:	Dates of Service:	
Sex therapy issues seen at this location:		
Type of sex therapy at this location (in hours): ____ Couples ____ Individual Adult Males ____ Individual Adult Females ____ Group (Males) ____ Group (Females) ____ Minors		

Place of service:		Hours of sex therapy at this location:
Position:	Dates of Service:	
Sex therapy issues seen at this location:		
Type of sex therapy at this location (in hours): ____ Couples ____ Individual Adult Males ____ Individual Adult Females ____ Group (Males) ____ Group (Females) ____ Minors		

Place of service:		Hours of sex therapy at this location:
Position:	Dates of Service:	
Sex therapy issues seen at this location:		
Type of sex therapy at this location (in hours): ____ Couples ____ Individual Adult Males ____ Individual Adult Females ____ Group (Males) ____ Group (Females) ____ Minors		

Total: ____ **Couples** ____ **Individual Adult Males** ____ **Individual Adult Females** ____ **Group (Males)** ____ **Group (Females)** ____ **Minors**

Total Hours ______

Name: _____

Verification of 50 hours of supervision in sex therapy

Applicants must document at least 50 hours of supervision with an approved sex therapist.

Each supervisor listed must submit both:

1) a Supervisor Report (Appendix A) and,
2) a Professional Reference (Appendix B).

Supervision requirements:

- Supervisors must be approved by ABCST for supervision hours to count toward the requirement. ABCST retains the right to not approve supervision hours if the supervisor was not approved in advance and does not meet criteria as a supervisor.
  - Certified sex therapists having 3 years' experience after being certified by ABCST, AASECT, or ABS are approved supervisors. Additionally, the supervisor must believe they have the training and experience to ethically provide supervision.
  - To obtain approval for supervisors who do not meet the above, contact ABCST with a letter expressing your desire to have them approved and a C.V. of the potential supervisor showing advanced training and experience in sex therapy.
- An hour of supervision can only be counted if the primary focus of the supervision was for a case(s) involving a sex-related diagnosis where the supervisee was the (primary) therapist.
  - Co-therapy (with the supervisor as co-therapist) may be counted if the supervisee is the primary therapist for the hour counted. Co-therapy may be counted as live supervision.
  - While supervision will include looking at the therapist's own issues and how they impact therapy (self of the therapist work), personal therapy does not meet supervision requirements.
  - Primarily didactic formats (i.e., workshop, seminar, class) do not meet supervision requirements, even if the supervisee is teaching and the supervisor is observing.
  - Administrative meetings do not meet supervision requirements.
- The minimum 50 hours must be completed within a five-year (60 month) period of time.
- At least 10% of the supervision must be live or include review of audio or video recordings of the supervisee providing sex therapy.
- No more than 50% of supervision may be group supervision (3 or more supervisees). No more than 50% of hours qualifying toward the "live" requirement may be group supervision.

ISW Students Only:

Group supervision hours are typically given for case consultation time spent with professors in ISW advanced courses (7552, 7572, 7582, and 7592). There is no need to obtain supervisor signature or professional reference for these hours. Please complete the following for credit toward supervision hours given in class.

Advanced course completed:	**Session (i.e., summer 2015):**	**Hours credited:**
☐ Advanced Sexual Addictions		
☐ Advanced Sexual Trauma and Abuse		
☐ Homosexuality and Sexual Identity		
☐ Advanced Sex Therapy		
Total group supervision hours earned in class:		

Name: ______________________________

Supervision of Sex Therapy

(Photocopy as many sheets as needed)

Supervisor:		Hours:
Setting:	Dates:	
Sex therapy issues supervise:		
Type of supervision (in hours): ____ Group Case consult ____ Individual Case Consult ____ Audio ____ Video ____ Co-therapy ____ Live observation of therapy		

Supervisor:		Hours:
Setting:	Dates:	
Sex therapy issues supervise:		
Type of supervision (in hours): ____ Group Case consult ____ Individual Case Consult ____ Audio ____ Video ____ Co-therapy ____ Live observation of therapy		

Supervisor:		Hours:
Setting:	Dates:	
Sex therapy issues supervise:		
Type of supervision (in hours): ____ Group Case consult ____ Individual Case Consult ____ Audio ____ Video ____ Co-therapy ____ Live observation of therapy		

Supervisor:		Hours:
Setting:	Dates:	
Sex therapy issues supervise:		
Type of supervision (in hours): ____ Group Case consult ____ Individual Case Consult ____ Audio ____ Video ____ Co-therapy ____ Live observation of therapy		

Supervisor:		Hours:
Setting:	Dates:	
Sex therapy issues supervise:		
Type of supervision (in hours): ____ Group Case consult ____ Individual Case Consult ____ Audio ____ Video ____ Co-therapy ____ Live observation of therapy		

☐ Mark if supervision hours are included on additional pages.

Total: ____ **Group Case consult** ____ **Individual Case Consult** ____ **Audio** ____ **Video** ____ **Co-therapy** ____ **Live observation**

Percentage of Live/Video/Audio _____ **Total Hours ______**

Name: _____

STATEMENT OF FAITH

The American Board of Christian Sex Therapists is unique in our commitment to integrating professional standards and the Christian faith within the field of sex therapy. Applicants to ABCST must be able to agree with the Statement of Faith appearing below. (This Statement of Faith comes from the National Association of Evangelicals and has been affirmed by more than seventy denominations and represents a broad evangelical consensus.)

Statement of Faith

- We believe the Bible to be inspired, the only infallible, authoritative Word of God.
- We believe that there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.
- We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.
- We believe that for the salvation of lost and sinful man, regeneration by the Holy Spirit is absolutely essential.
- We believe in the present ministry of the Holy Spirit by whom the Christian is enabled to live a godly life.
- We believe in the resurrection of both the saved and the lost; they that are saved unto the resurrection of life and they that are lost unto the resurrection of damnation.
- We believe in the spiritual unity of believers in our Lord Jesus Christ.

In addition to a general statement of faith, ABCST members share a general theology of sexuality. While we know there will be difference of opinion on the specifics, it is expected that therapists certified by ABCST agree with, and counsel their clients in accordance with, the following statement:

General Theology of Sexuality

- Our sexuality is part of God's creation and is a good gift from God intended for us to take delight in;
- God's revealed will for sexual expression includes sexual fidelity in marriage and chastity outside of marriage;
- Sexuality, like all parts of who we are as persons, has been affected by the Fall as evidenced by desires that are not in keeping with God's will for sexual expression;
- God is working in our lives to redeem His people, and we, as sexual beings, participate in that redemptive experience;
- Ultimately, all of our incompleteness will be made complete in God's economy, as God's purposes to redeem His creation are fulfilled in Glorification

____ My initials confirm my agreement with the above *Statement of Faith* and *General Theology of Sex*.

PERSONAL THEOLOGY OF SEX

Each applicant must submit a 5-10 page paper reflecting their personal theology of sex. The purpose of this submission is not to judge the applicants personal theology but to confirm that they have thought through the integration of theology with sexuality. Applicants may write a general paper evidencing their overall theology of sex or may select specific sexual issues and discuss the theological integration of that particular issue.

While this is a personal statement, papers are expected to be professional in nature. They should be submitted in APA format and include appropriate references for material presented. Previously published material is acceptable.

Be sure to enclose two (2) copies of your paper with your submission.

Name: _____

REFERENCES

We require two types of reference with your application. The nature of these references is listed below.

NOTE: You are not allowed to pay, or in any way reimburse those individuals who are providing references for you. You are encouraged to provide them a stamped and addressed envelope to facilitate the mailing of the reference to us.

1. Professional Reference (Appendix B)

The first set of references should speak to your competence and character as a sex therapist. Each of your supervisors is required to complete a Professional Reference. Since the burden of proof is on you, the applicant, to support your competence as a sex therapist, you are invited to, but not required to, include up to two (2) other professional references. Please list below the individuals you have requested to fill out a professional reference for you.

Name of reference	Nature of Reference	Office Use
	☐ Supervisor ☐ Other Professional	
	☐ Supervisor ☐ Other Professional	
	☐ Supervisor ☐ Other Professional	
	☐ Supervisor ☐ Other Professional	
	☐ Supervisor ☐ Other Professional	
	☐ Supervisor ☐ Other Professional	

2. Faith and Character Reference (Appendix C)

The second reference should speak to your faith and character as a Christian professional. Please ask a pastor who knows you or another spiritual leader in your life to complete this reference for you. You are required to submit one reference, but since the burden of proof is on you, the applicant, to support your faith and character as a Christian professional, you may choose to request a total of two individuals to complete this form. Please list below the individual(s) you have requested to fill out a faith and character reference for you.

Name of reference	Nature of Relationship	Office Use

Statement of Confidentiality

We require that the above references be submitted and maintained as confidential references.

In initialing below and signing the application form I agree to waive any rights the law might allow in seeking to review or otherwise learn the contents of the professional reference(s) or faith and character reference(s) sent in as a part of my certification application. I understand these will be available only to the ABCST board and certification committee.

Applicant's initials _____

Name: _____

SIGNATURE PAGE

I, the undersigned, verify that the information included with this application packet has been voluntarily supplied for the purpose of being certified as a Sex Therapist by the American Board of Christian Sex Therapists. I verify that the information enclosed in this application is accurate to the best of my knowledge and authorize ABCST to verify this information. I understand that in the process of verifying the included information these facts might become known to third parties. I expressly waive any claim to confidentiality of the material enclosed in this application packet except where otherwise stated.

I understand this application packet will be reviewed by the Certification Committee of the American Board of Christian Sex Therapists in accordance with the by-laws of the American Board of Christian Sex Therapists. I understand I can request a copy of these by-laws at any time and that my application will be evaluated based on the standards in place at the time I submit my application.

Finally, while effort has been made to keep the application and review process objective, I understand there is a subjective part to evaluating my application. I acknowledge that if my application is not accepted I can appeal as established in the bylaws but that the decision of the certifying committee is final. I agree that I am voluntarily submitting this application and that if my application is not accepted I will in no way seek to hold ABCST or any of its officers, committee members, or members liable for such action.

I have enclosed the required application fee and understand it is non-refundable. If my application is accepted I will be notified and will pay the annual membership fee of $_____.____. I understand I will need to renew my application every other year and verify completion of required CEU's.

Should any information included in this application change that affects my membership, I will notify ABCST within 14 days.

Please mark (☑) each of the following:

- ☐ I have read and agree to the above.
- ☐ I verify that the information I have included in this application is accurate.
- ☐ I agree with ABCST's Statement of Faith and General Theology of Sexuality.
- ☐ I request certification as a Sex Therapist through ABCST.

_____ _____

Printed Name Signature

Date ___/___/_____

SUPERVISOR REPORT

Each supervisor listed must submit (in a separate envelope) a completed copy of the following form.

Applicant's Name _____

This form is to verify your supervision with the above applicant. Please complete this form **and** a Professional Reference form for the above applicant. Mail completed form to:

American Board of Christian Sex Therapists, 1325 Satellite Blvd NW, Ste 102, Suwanee, GA 30024

About you

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I supervised the above applicant from _____ (month/year) to _____ (month/year)

The applicant performed _____ hours of sex therapy while under my supervision.

I provided the applicant with a total of _____ hours of sex therapy supervision. The breakdown for these hours were as follows:

____ Group case consult
____ Individual case consult
____ Audio review of session
____ Video review of session
____ Live observation of session
____ Co-therapy (applicant as lead therapist)

The cases seen by the applicant while under my supervision included: (check all that apply)

☐ Adult males ☐ Adult females ☐ Couples
☐ Minors ☐ Families ☐ Groups

Please provide a brief recommendation of why you would/would not support the applicant being certified as a sex therapist based on your supervision with them.

Do you have any reason to doubt the applicant will be ethical in their duties as a sex therapist?

Please identify your impression of the applicant's experience and competence in working with various sex therapy issues

.

Rank applicant's **experience** as follows:	Rank applicant's **Competence** as follows.
0 – No experience in therapy with this issue. 1 – Worked with this issue in a couple cases. 2 – Saw this issue occasionally in therapy. 3 – Worked with this issue often in therapy. 4 – Worked with this issue in most cases in their practice.	0 – It would be unethical for the applicant to work with this issue. 1 – He/she is able to work with this issue when necessary but is not very competent 2 – He/she has the basic skills and competence needed to work with this issue in therapy. 3 – He/she works comfortably with this issue and clients improve under his/her care. 4 – He/she is very skilled and knowledgeable in this issue

	Experience	Competence
Hypoactive Sexual Desire Disorder	0—1—2—3—4	0—1—2—3—4
Sexual Aversion Disorder	0—1—2—3—4	0—1—2—3—4
Female Sexual Arousal Disorder	0—1—2—3—4	0—1—2—3—4
Male Erectile Disorder	0—1—2—3—4	0—1—2—3—4
Female Orgasmic Disorder	0—1—2—3—4	0—1—2—3—4
Male Orgasmic Disorder	0—1—2—3—4	0—1—2—3—4
Premature Ejaculation	0—1—2—3—4	0—1—2—3—4
Dyspareunia	0—1—2—3—4	0—1—2—3—4
Vaginismus	0—1—2—3—4	0—1—2—3—4
Sexual Masochism	0—1—2—3—4	0—1—2—3—4
Sexual Sadism	0—1—2—3—4	0—1—2—3—4
Voyerism	0—1—2—3—4	0—1—2—3—4
Exhibitionism	0—1—2—3—4	0—1—2—3—4
Fetishism	0—1—2—3—4	0—1—2—3—4
Other Paraphillias	0—1—2—3—4	0—1—2—3—4
Gender Identity Disorder	0—1—2—3—4	0—1—2—3—4
Sexual Abuse Recovery	0—1—2—3—4	0—1—2—3—4
Sexual Perpertrators	0—1—2—3—4	0—1—2—3—4
Sexual Addiction	0—1—2—3—4	0—1—2—3—4
Incest	0—1—2—3—4	0—1—2—3—4
	0—1—2—3—4	0—1—2—3—4
	0—1—2—3—4	0—1—2—3—4
	0—1—2—3—4	0—1—2—3—4
	0—1—2—3—4	0—1—2—3—4

_____ _____ _____/___/_____

Printed Name Signature Date

PROFESSIONAL REFERENCE - CONFIDENTIAL

To be completed by a therapy professional who can speak to your work as a sex therapist.

Applicant's Name _____

Instructions

The above named individual is applying for certification as a sex therapist by the American Board of Christian Sex Therapists. You have been asked to provide a professional reference for this individual. Please fill out the following form and mail it in a sealed envelope to: ABCST, 1325 Satellite Blvd NW, Ste 1502, Suwanee, GA 30024
Note: This form is confidential. The applicant has signed a waiver assuring the information on this form will be held in confidence. Only those responsible for reviewing the application packet will review the information on this form.

About you

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Length of time you have known the applicant? _____

How well do you believe you know this applicant? _____

Please describe the nature of your relationship to applicant:

Please comment on the applicant's qualifications for certification as a sex therapist.
(Use the reverse if necessary)

Would you recommend the applicant for certification as a sex therapist?

☐ - No ☐ - With reservation ☐ - Yes ☐ - Highly

Do you know of any condition of the applicant which might impair their competency as a sex therapist?

Using the scale below, rate the applicant's overall ability as a sex therapist.

• ---------- • ----------• ---------- • ----------•

Poor Fair Good Very Good Excellent

Would you refer individuals to the applicant for sex therapy?

_____ _____ _____/___/_____

Printed Name Signature Date

Continued on next page.

FAITH AND CHARACTER REFERENCE - CONFIDENTIAL

This page is to be completed by your pastor or other spiritual leader.

Applicant's Name _____

Instructions

The above named individual is applying for certification as a sex therapist by the American Board of Christian Sex Therapists. You have been asked to provide a faith and character reference for this individual. Please fill out the following form and mail it in a sealed envelope to: ABCST, 1325 Satellite Blvd NW, Suite 1502, Suwanee, GA 30024 **Note: This form is confidential**. The applicant has signed a waiver assuring the information on this form will be held in confidence. Only those responsible for reviewing the application packet will review the information on this form.

About you

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Length of time you have known the applicant? _____

How well do you believe you know this applicant? _____

Please describe the nature of your relationship to applicant:

Do you see evidence of applicant's personal relationship with Christ?

Please describe applicant's character:

Continued on next page.

Applicant name _____

Please describe the applicant's faith.

Please identify any concerns you would have in the applicant becoming a sex therapist.

Would you recommend the applicant for certification as a sex therapist?

☐ - No ☐ - With reservation ☐ - Yes ☐ - Highly

_____ _____ ____/___/____

Printed Name Signature Date

Appendix D – Additional Work History

Enter additional work history here that wouldn't fit earlier in application. Only relevant work is necessary.

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

Where	Position	From	To
Responsibilities			

APPENDIX E – LICENSE ALTERNATIVE

All US states license therapy professionals in the following:

- Marriage & Family Therapy (www.aamft.org).
- Professional Counseling (Licensed Professional Counselors, Licensed Clinical Professional Counselors, or Licensed Mental Health Counselors – www.counseling.org)
- Social Work (contact state licensing board)
- Psychologist (www.apa.org)

As these options are available in each state, approving an applicant without one of the above licenses is unlikely. Note that it is the applicant's responsibility to convince the certification committee that they meet the requirements for certification (i.e., have commensurate training and experience to a licensed professional). Please include the information you feel is necessary while keeping it concise and easy to understand.

I believe I qualify for license alternative as I am:

- ☐ Certified by the American Nursing Association as a Clinical Specialist or Nurse Practitioner in Adult Psychiatric and Mental Health Nursing Clinical Specialist.
- ☐ Certified by the American Nursing Association as a Nurse Practitioner in Child and Adolescent Psychiatric and Mental Health Nursing.

Note: If you checked the above, you must include documentation verifying such.

If you do not qualify for one of the above license alternatives but believe you have sufficient training, supervision and experience to qualify you may submit a written appeal with documentation to support your claim.