



Personal Information			
First Name		Initial	
Last Name		Suffix	
Preferred Pronouns			
Birthdate (DD/MM/YY)			
Street Address			
Apartment			
City/Town		State	
Zip Code		Country	
Phone Number			
Email Address			

Professional Information	
Highest Degree Awarded (M.A., M.S., Ph.D., M.D.)	
Educational Institution Awarding This Degree	
Title of Degree Program or Degree Awarded	
Month and Year This Degree Was Awarded	
Other Degree(s) Awarded	
Educational Institution Awarding This Degree	
Title of Degree Program or Degree Awarded	
Month and Year This Degree Was Awarded	
Professional License (State)	
Professional License (Number)	

Business Information			
Name of Counseling Practice			
Provider Group (If Applicable)			
Street Address of Business			
Office or Suite Number			
City/Town		State	
Zip Code		Country	
Business Phone Number			
Business Website Address			

Agreements	
I have read and agree to the <a href="#">privacy policy</a> .	YES <input type="radio"/>
I have provided a Biography to be posted on the membership directory page.	YES <input type="radio"/>
I have provided an Essay on how I plan to use Conifold Theory in my practice.	YES <input type="radio"/>
I have provided proof of my degree in mental health practice.	YES <input type="radio"/>
I have provided proof of my state licensing in mental health practice.	YES <input type="radio"/>
Signature	Date

The Conifold Counseling Services privacy policy can be found at: <https://www.conifoldcounseling.com/policies>.

Please enter your information into this form, and send the completed documents to: [contact@conifoldcounseling.com](mailto:contact@conifoldcounseling.com).

