

EMDR Lebanon Association

Decree # 691 - Foundation Date Apr. 25, 2013

Application Form

Date: / / .

I. Applicant Information:

First Name:	Father's Name:	Last Name:
--------------------	-----------------------	-------------------

Gender: <input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth: / /
--	---------------------------

Nationality(ies): First:	Second (if any):
------------------------------------	------------------

Languages:	Fluent (put x)	Good	Satisfactory	Weak
1.				
2.				
3.				

Home Address:		
Country:	City:	Area/region:
Street:	Building:	Floor:

Contacts:

Land Telephone:	Mobile:
P.O. Box:	

Email Addresses:

1-
2-

II. Education & Experience:

University degrees (starting with the most recent):

Degree	Specialization	University	Year	Country

EMDR Certificate(s):

Name of Certificate	Trainer(s)	Name of Institution	Year	Country

Other Certificates:

Type	Specialization	Name of Institution	Year	Country

Training experience:

Type of training received:
Number of years:
Psychotherapeutic approaches trained in:

III. Current Work:

Current job(s) & position: (list if more than one job)			
1.			
2.			
3.			
Type of work:	<input type="checkbox"/> private practice	<input type="checkbox"/> full-time in an institution	<input type="checkbox"/> Part-time in an institution
Name of institution(s):			
1.	<input type="checkbox"/> Non-profit /NGO	<input type="checkbox"/> Private sector	
2.	<input type="checkbox"/> Non-profit /NGO	<input type="checkbox"/> Private sector	
Work Address:			
Country:	City:	Area/region:	
Street:	Building:	Floor:	

Clinical experience:

Number of years of experience after the Master degree:
Type of experience:

Types of psychotherapy used: (put an x beside those that fit)

<input type="checkbox"/> Psychoanalysis	<input type="checkbox"/> Humanistic therapy
<input type="checkbox"/> Cognitive behavior therapy	<input type="checkbox"/> Group therapy
<input type="checkbox"/> Behavior therapy	<input type="checkbox"/> Others:

Psychological Disorders you work with: (put an x beside those that fit)

<input type="checkbox"/> Anxiety disorders (<i>Panic, OCD, phobias...</i>)	<input type="checkbox"/> Cognitive Disorders (<i>Dementia, Alzheimer's...</i>)
<input type="checkbox"/> Post-Traumatic Stress Disorder	<input type="checkbox"/> Dissociative Disorders
<input type="checkbox"/> Depression	<input type="checkbox"/> Addictions
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Personality disorders
<input type="checkbox"/> Developmental Disorders (<i>Communication disorders, Mental retardation, LD, Autism...</i>)	<input type="checkbox"/> Behavior disorders (<i>ADHD, Oppositional Defiant Disorder, Conduct Disorder</i>)

Population you do treatment on: (put an x beside those that fit)

<input type="checkbox"/>	Infant/toddlers (0 -3y)
<input type="checkbox"/>	Children (3y-12y)
<input type="checkbox"/>	Adolescents (13y-17y)
<input type="checkbox"/>	Adults
<input type="checkbox"/>	Couples
<input type="checkbox"/>	Group
<input type="checkbox"/>	Families
<input type="checkbox"/>	Elderly

I certify that information contained in this application is true and complete. I understand that false information may be grounds for the termination of my membership in EMDR Lebanon Association. I authorize the verification of any or all information listed above.

Signature _____

Date _____

YOU MUST SUBMIT ALL REQUIRED DOCUMENTATION IN ORDER FOR YOUR MEMBERSHIP TO BE PROCESSED. SEE THE PREVIOUS PAGE FOR DETAILS.
