

AMERICAN BOARD OF BEHAVIORAL HEALTHCARE PRACTICE

APPLICATION FOR BOARD CERTIFICATION

I hereby apply to the ABBHP for the purpose of board certification in the specialty of Behavioral Healthcare Practice. Please review ABBHP Requirements on the ABBHP website at www.abbhp.org

Date: ____/____/____

GENERAL REQUIREMENTS

1. Name _____
Last First MI

2. Work Address _____ Phone _____
_____ Fax _____
City State Zip

Home Address _____ Phone _____
_____ Email _____
City State Zip

Preferred Mailing Address () Office () Home

3. Current Licensure at the independent level:

State	Lic. No.	Lic. Title
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Doctoral Degree is: () Ph.D. () Psy.D. () Ed.D. () D.BH () D.MH

Year Degree Awarded _____

Institution _____ Department _____

5. Have You Completed A Post Doctoral Internship of at least 1500 hours? Yes () No ()
Program Name: _____
Location: _____
Date Completed: ____/____/____

6. Have you ever been convicted of a felony? Yes () No ()
a. Sued for malpractice? Yes () No ()
b. Charged with an ethics or conduct violation that resulted in an adverse decision or action, including censure, probation, suspension or revocation of your license to practice?
Yes () No ()

*If yes to any of the above questions, include a complete statement of details on a separate page.

*****Please attach a copy of your current license and a current vita with this application.*****

ENDORSEMENTS

7. Along with this application, please arrange for at least one letter of endorsement by appropriately qualified professionals, preferably a primary care physician, who is familiar with your competence and work as a healthcare professional. Including the letter with the application expedites the application process. However, it may be sent directly to ABBHP.

CURRENT EXPERIENCE

8. Work Place: _____ Dates (from) _____ (to) _____
Address _____
Title or Position _____
Professional Supervisor _____
(Professional person best able to evaluate your work)
Hours per week at this location: _____
Describe your professional activities. If engaged in private practice, indicate extent and nature (types of patients and types of service, e.g., psychotherapy, psychoeducational assessment, consultation, etc).
Description of Duties:

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PAST EXPERIENCE

8a. Work Place: _____ Dates (from) _____ (to) _____
Address _____
Title or Position _____
Professional Supervisor _____
(Professional person best able to evaluate your work)
Hours per week at this location: _____
Describe your professional activities. If engaged in private practice, indicate extent and nature (types of patients and types of service, e.g., psychotherapy, psychoeducational assessment, consultation, etc).
Description of Duties:

8b. Work Place: _____ Dates (from) _____ (to) _____

Address _____

Title or Position _____

Professional Supervisor _____

(Professional person best able to evaluate your work)

Hours per week at this location: _____

Describe your professional activities. If engaged in private practice, indicate extent and nature (types of patients and types of service, e.g., psychotherapy, psychoeducational assessment, consultation, etc).

Description of Duties:

9. Do you have any current board certifications? Yes () No ()

If yes, please describe.

a. Name of Board: _____

Specialty: _____ Date Received: ____/____/____

b. Name of Board: _____

Specialty: _____ Date Received: ____/____/____

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10. Membership in Professional Organizations:

1. _____

2. _____

3. _____

HOSPITAL PRIVILEGES

11. Do you currently have hospital privileges? Yes () No ()

If yes, please provide the name of the hospital.

Hospital: _____

City: _____ State _____ ZIP: _____

Name of Medical Director: _____

12. WORK PRODUCT

A practice sample that demonstrates your work in behavioral healthcare. This may consist of a redacted case involving a recent assessment, case formulation, treatment plan, termination summary, or any other sample acceptable to the ABBHP board.

ATTESTATION

I, the undersigned, hereby make this application to the American Board of Behavioral Healthcare Practice, for board certification as a Diplomat in Behavioral Healthcare Practice. I understand that my application is subject to the rules, bylaws, and other governing provisions of the Board, and I agree to be bound by the regulations of the Board, either as a candidate for issuance of a Diplomat, or upon issuance of a Diplomat, as the holder of same. I agree to disqualification from examination, or issuance of a Diplomat, or forfeiture of any Diplomat issued to me in the event that the Board finds me in violation of its rules and regulations. I recognize that the Board may decide that I am not qualified, and I agree to abide by its decision.

I certify that all the statements made herein are true and accurate to the best of my knowledge and belief. I have enclosed the non-refundable application fee.

If granted board certification, I agree ABBHP is an active credential that requires annual renewal and associated attestation and fee and to pay all required annual fees assessed by the American Board of Behavioral Healthcare Practice.

Signature: _____ Date: ____/____/____

Printed Name: _____

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FEES

Application Fee: \$125.00

Are you currently a member of the National Alliance of Professional Psychology Providers (NAPPP) or a member of an affiliate of NAPPP? Yes () No ()

If yes, fee is reduced to \$75.00.

NOTE: If your application is accepted, you will be required to successfully pass either the Behavioral Healthcare Examination or the Oral Examination, if that is selected. The fee for the Behavioral Healthcare Examination is \$200.00. The fee for the Oral Examination is \$300.00. *NAPPP members or members of NAPPP affiliates are eligible for a \$50.00 reduction of these fees.* The Board reserves the right to change its schedule of fees at any time during the course of candidacy.

*****FEES ARE NOT REFUNDABLE.*****

Please return application with all requested materials to:

American Board of Behavioral Healthcare Practice
PO BOX 6263
Garden Grove, CA 92846

Tel: 714 927-4439
Fax: 562-342-9999
E-MAIL: info@abbhp.org

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ABBHP Applicant Agreement

Terms and Conditions Of Accreditation

In consideration of the mutual benefits accruing and expected to accrue hereunder, ABBHP and the Applicant, agree as follows:

For purposes of the following provisions, 'Applicant' means

[Name of Person Seeking Board Certification.

1. Applicant hereby authorizes ABBHP and each of its designees, for any and all purposes reasonably related to Applicant's application and ongoing board certification relationship to ABBHP, to use any and all information submitted by Applicant provided that ABBHP and each of its designees shall take reasonable steps to hold and keep in confidence such information. Notwithstanding the foregoing duty of confidentiality, Applicant hereby authorizes ABBHP to publicly disclose on ABBHP's web site and in comparable ABBHP publications the fact that Applicant has received ABBHP board certification and the Applicant's name in connection therewith and the current status of the applicant's continued board certification.

2. Applicant hereby releases and discharges ABBHP and each of its designees, individually and in their official capacity, from any and all claims or causes of action of any nature arising out of the **acceptance and review**, and **approval** or **disapproval** of Applicant's application, or, if approved, ABBHP's implementation and application of the board certification.

I, _____, agree to the terms and conditions of this application hereby agree to and accept the terms and conditions of applying for board certification by ABBHP.

Signed: _____

Print Name: _____

Title: _____

Date: ____/____/____

AMERICAN BOARD OF BEHAVIORAL HEALTHCARE PRACTICE

CHECK LIST

Tel: (714) 927-4439

Fax: (562) 342-9991

www.ABBHP.org

Name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Telephone: _____

Email: _____

Amount Enclosed: \$ _____

Date: ____/____/____

Check Off

1. Signed and Completed Application Form: _____
2. Agreement Form: _____
3. Copy of State License: _____
4. Copy of Work Sample: _____
5. Letter of Endorsement: _____
6. Copy of Doctoral Degree: _____
7. Check For \$125.00: _____
8. This Form: _____

Please mail this form with your registration fee to:
American Board of Behavioral Healthcare Practice
P.O. Box 6263
Garden Grove, CA 92846