

American Psychotherapy Association

Recertification Continuing Education Reporting Form

TYPE OF CERTIFICATION:
(Please circle)

BCPC	CRS
PTSD-Counselor	PTSD-Clinician
Master Therapist	

Date: ____/____/____

Email: _____

Name: _____

Member ID#: _____

All certifications are for a three (3) year period. In compliance with third-party accreditation, American Psychotherapy Association requires certification holders to submit the required 30 continuing education units every three years for recertification and uphold the American Psychotherapy Association Code of Conduct.

To avoid delays in processing your certification, please follow these steps:

- Supporting documents should be submitted in the same order as the activities are listed.
- Classes should have a certificate/letter of completion that includes classroom/training hours with date and time.
- Sign the completed form.
- Do not send original documents. Keep the original documents for personal records.

1. EDUCATIONAL PROGRAMS (Including, but not limited to certification courses, seminars/conferences, correspondence/self study, college courses) Documentation is required (e.g. certification of completion, transcript, official government orders, or other acknowledgement of completion).

Organization			CE Credit Claimed	Approved CE <i>For office use only</i>
Program Title or Description				
Location	Dates	Hours		
Organization				
Program Title or Description				
Location	Dates	Hours		
Organization				
Program Title or Description				
Location	Dates	Hours		
Organization				
Program Title or Description				
Location	Dates	Hours		
Organization				
Program Title or Description				
Location	Dates	Hours		

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2. COURSES TAUGHT Documentation is required (e.g., letter/certificate of appreciation, award, other acknowledgement of service)

Organization	Your Position		CE Credit Claimed	Approved CE <i>For office use only</i>
Program Title or Description				
Location	Dates	Hours		
Organization	Your Position			
Program Title or Description				
Location	Dates	Hours		
Organization	Your Position			
Program Title or Description				
Location	Dates	Hours		
Organization	Your Position			
Program Title or Description				
Location	Dates	Hours		
Organization	Your Position			
Program Title or Description				
Location	Dates	Hours		
Organization	Your Position			
Program Title or Description				
Location	Dates	Hours		

3. AUTHOR Documentation is required (e.g., letter from publisher, copy of article with publication date, etc.)

Title of Contribution	CE Credit Claimed	For office use only
Publication	Date of Publication	
Title of Contribution		
Publication	Date of Publication	
Title of Contribution		
Publication	Date of Publication	
Title of Contribution		
Publication	Date of Publication	
Title of Contribution		
Publication	Date of Publication	

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6. PUBLIC SERVICE (must be in the same field as the certification)

7. OTHER ACCOMPLISHMENTS (must in the same field as the certification)

Have you been convicted of a criminal offense or have had any disciplinary or legal action taken against you? ___ No ___ Yes (please explain)

I certify that all statements, answers and representations made in this report are accurate to the best of my knowledge.

Signature: _____ | DATE: _____

Mailing Address Update

Circle ONE: **Business** **Home**

Address:	
Phone:	Fax:
Email:	

FOR STAFF USE ONLY
Total Approved Points this Report _____
Total Approved Points To Date _____
Signature _____
Date ____/____/____