

COURT INVOLVED THERAPIST LIST INTAKE SHEET

If you are interested in being included on the Court Involved Therapist List, compiled by the Mental Health Liaison Committee, a Subcommittee of the Family Law Steering Committee of the Sonoma County Bar Association, please complete the following form and return it to the address listed below with a \$20 processing fee (payable to SCBA).

Name: _____
Address: _____
Phone: _____ Email: _____ Website: _____

Professional designation M.D. Ph.D. EDD LCSW MFT Other: _____
Professional Degree: _____ Date Acquired: _____
License Type: _____ License Number: _____ Date Acquired: _____

I hereby certify under penalty of perjury under the laws of the State of California that I am licensed in good standing in the State of California. _____
Signature Date

I am exempt from licensure requirements by the laws of the State of California. (Please attach an explanation. We may contact you for additional information.)

Please describe your training in court-involved work: _____

When working with a child do you typically meet with one parent or with both parents? _____

Are you willing to communicate with child custody recommending counselors, judges, and/or attorneys?

Yes No

I have read the Association of Family and Conciliation Courts' Guidelines for Court Involved Therapy and certify that I am in compliance with the guidelines. The following is a link to the guidelines:

<https://www.afccnet.org/Portals/0/PublicDocuments/CEFCP/Guidelines%20for%20Court%20Involved%20Therapy%20AFCC.pdf>

Signature Date

Specialty Areas of Practice (Please check all that apply):

<input type="checkbox"/> Adolescent Therapy	<input type="checkbox"/> Family Therapy
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> High Conflict Co-Parent Counseling
<input type="checkbox"/> Child Abuse Assessment and Treatment	<input type="checkbox"/> Individual Therapy
<input type="checkbox"/> Child Specialist	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Child Therapy	<input type="checkbox"/> Oppositional and Conduct Disorders
<input type="checkbox"/> Child/Teen Therapy for Divorce Related Concerns	<input type="checkbox"/> Parent Child Reunification Counseling
<input type="checkbox"/> Co-Parent Counseling	<input type="checkbox"/> Post Traumatic Stress Disorders
<input type="checkbox"/> Couple/Marriage Counseling	<input type="checkbox"/> Private Child Custody Recommending Counseling
<input type="checkbox"/> Custody Evaluator	<input type="checkbox"/> Special Master/Parenting Coordinator
<input type="checkbox"/> Depressive Disorders	<input type="checkbox"/> Substance Abuse Counseling
<input type="checkbox"/> Developmental Disorders (Autism, Aspergers)	<input type="checkbox"/> Suicide Assessment
<input type="checkbox"/> Domestic Violence	

Return completed form and \$20 processing fee to: Susan Barrett, 829 Sonoma Avenue, Santa Rosa, CA 95404. Make checks payable to SCBA.