

Trauma Consultation Training Program

**Application**

Application deadline is August 15

**General Information**

Name \_\_\_\_\_ Date: \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Employer's Name & Address \_\_\_\_\_  
\_\_\_\_\_

Employer's Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**Education**

Degree \_\_\_\_\_ Year Completed \_\_\_\_\_ Institution \_\_\_\_\_

Degree \_\_\_\_\_ Year Completed \_\_\_\_\_ Institution \_\_\_\_\_

Degree \_\_\_\_\_ Year Completed \_\_\_\_\_ Institution \_\_\_\_\_

Are you licensed by the State of Illinois?  No.  Yes. Type of License \_\_\_\_\_ License number \_\_\_\_\_

Professional Therapy Training *list supervision, certificate programs, courses, etc.*

Year	Organization / School	Title of Training

**Employment**

Place of Employment \_\_\_\_\_

Discuss Experience working with traumatized populations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Length of Employment: from \_\_\_\_\_ to \_\_\_\_\_

Place of Employment \_\_\_\_\_

Discuss Experience working with traumatized populations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Length of Employment: from \_\_\_\_\_ to \_\_\_\_\_

**References**

Please list two colleagues or supervisors who could speak to us about your work

1. \_\_\_\_\_ ( \_\_\_\_\_ )  
Name Position Telephone

2. \_\_\_\_\_ ( \_\_\_\_\_ )  
Name Position Telephone

**Questions**

What interests you about the Trauma Consultation Group? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are some goals you want to achieve after attending this consultation group?

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

I certify all the above information is accurate and true

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return this form and a \$25.00 nonrefundable application fee to:

Womencare Counseling Center  
1740 Ridge Avenue, Suite 201  
Evanston, IL 60201  
Attn: Laurie Kahn

Application deadline: August 15. If you have any questions please call Laurie Kahn at 847-475-7003