



# Trauma Consultation Training Program Application

**Application deadline is August 1st**

## General Information

Name and Pronouns _____	Credentials _____
Home Address _____	City _____ Zip _____
Cell Phone: _____	Work Phone _____
Email (personal) _____	Email (work) _____
Employer Name _____	
Employer Address _____	City _____ Zip _____

## Education

Degree _____	Yr. Completed _____	Institution _____
Degree _____	Yr. Completed _____	Institution _____
Degree _____	Yr. Completed _____	Institution _____
Are you licensed by the State of Illinois? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of License _____	License Number _____
Professional Therapy Training: List certificate programs, supervision, intensive trainings, etc.:		
Year	Organization/School	Title of Training



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**Discuss your experiences working with traumatized populations:**

## Employment History

Organization Name

Title

Year(s)

\_\_\_\_\_

\_\_\_\_\_

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## References

Please list three supervisors or colleagues who could speak to us about your clinical work:

Name

Position

Phone

1

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2

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3

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**What interests you about the Trauma Consultation Program?**



## Trauma Consultation Training Program Application

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

Where did you hear about the Trauma Consultation Training Program?

Please return this form along with a \$25.00 nonrefundable application fee to [info@womenscarecounseling.com](mailto:info@womenscarecounseling.com) or mail to:

**Womenscare Counseling Center  
Attn: TCG Application  
1740 Ridge Avenue, Suite 201  
Evanston, IL 60201**

I certify all the above information is accurate and I consent to its usage in applying for The Trauma Consultation Group:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Applications must be received by August 1.** Please call 847-475-7003 x21 with questions or to pay application fee by phone.