

The AGENCY

Application for
Membership

FOR EXCELLENCE IN CHRISTIAN COUNSELING

AECC, P.O. Box 770454, Eagle River, Alaska 99577
www.aeccounseling.com aeccadmin@gmail.com

This form must be filled out completely in order for it to be processed. The information provided is kept completely confidential and is not considered data available for public use. Only authorized AECC/UCSS personnel will have access to this application.

Date of Application _____

Application for: (check one)

Assoc. Coun. Cert. Coun. Assoc. Ther. Cert. Ther. Doc. Ther.

Title: Dr. Mr. Mrs. Ms. Rev. (Circle One) Other _____

Last Name _____ First _____ MI _____

Mailing Address _____

City _____ State _____ ZIP _____

Country _____

E-mail address _____ Website _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____

DOB _____ Sex: M F Martial Status _____ Spouse's Name _____

Occupation _____ Employer _____

Church (name) _____

Street or P.O. Box _____

City _____ State _____ ZIP _____

Denomination _____ Pastor's Name _____

Please list three personal (non-relative) references: (name, address, city, state, zip, phone num.)

1. _____
2. _____
3. _____

Academic Information

List those colleges and universities attended (use a separate sheet of paper if necessary). Please provide the institution's name, city and state.

_____ Degree Earned _____

_____ Degree Earned _____

_____ Degree Earned _____

_____ Degree Earned _____

_____ Degree Earned _____

Total Undergraduate Credits Earned _____ Total Graduate Credits Earned _____

Other organizations with which you currently hold or have held counseling credentials:

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By signing this application for membership, the applicant is agreeing to abide by all of the provisions and stipulations in the AECC handbook, without exclusion. This agreement between parties is binding by signature, whether faxed, mailed or rendered in person and initial payment is acceptable as a firm commitment in good faith by all parties.

Payment must accompany this application for membership in order to be processed. **All checks should be made out to: UCSS.**

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I, the undersigned, do understand the provisions of this application and the AECC handbook and agree to abide by them, without exclusion.

Applicant's Signature Date

<u>Annual Membership Payment Schedule</u>	
Associate Counselor - \$25.00 Certified Counselor - \$35.00 Associate Therapist - \$50.00 Certified Therapist - \$75.00 Doctoral Therapist - \$100.00	
For Office Use Only	
Board Examiner Signature	Date
Board Examiner Signature	Date
Board Examiner Signature	Date
Applicant approved for:	