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

Annual Membership Payment Schedule

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:

_____