ASSOCIATION OF BLACK PSYCHOLOGISTS (ABPsi)

Psychologist Listing Registration Form

Name:_____Highest Degree Earned:_____Year Degree Earned_____

Office Address:_____

City:_____State:_____Zip:_____Email: _____

Office Telephone #: ( )_____Ext._____Fax #: ( )_____

Check Area(s) of Specialty:

Clinical Psychology	☐	Depression	☐	Marital Therapy	☐	HIV/AIDS	☐	Sexual Abuse	☐	Adolescent Therapy	☐
Death & Dying	☐	Veterans	☐	Chemical	☐	Educational	☐	Assessment	☐	Crisis Intervention	☐
Family Therapy	☐	Dependency	☐	Testing	☐	Health	☐	Mental	☐	Trauma	☐
Gerontological	☐	Therapy	☐	LGBTQIA	☐	Retardation	☐	Intelligence/IQ Measurement	☐		

Other: _____

Please specify Insurance(s) accepted: _____

Please indicate the age group covered by your practice:

Age Groups Treated:	Early Childhood (2 – 12)	Adolescents (13 – 17)	Young Adults (18 – 21)	Adults (21 – 54)	Seniors (55 – Up)
	_____	_____	_____	_____	_____

Please provide the following information for our records only. This information will not be provided to the consumer.

LICENSURE

Are you licensed: YES_____ NO_____

What profession(s) are you licensed in?

_____

_____

State(s) Licensed: _____

License No.: _____

_____

National Certification(s) by: _____

CERTIFICATION

Are you certified? YES _____ NO _____

What specialty(ies) are you certified in?

_____

_____

State(s) Certified: _____

Certification No.: _____

_____

Certification No.: _____

Please Circle Type of Payment

Please make checks payable to The Association of Black Psychologists (ABPsi) 7119 Allentown Rd, Suite 203 Fort Washington, MD 20744

Check **M.O.** **Credit Card:** ***Visa*** ***MasterCard*** ***AMEX*** ***Discover***

☐ **1 Year Subscription $500** ☐ **2 Year Subscription $800** ☐ **3 Year Subscription $1200**

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Billing Address:_____ **Billing City:**_____ **Billing State**:_____

Amount: $ _____**Signature:**_____