

**APPLICATION FOR COUNSELOR TRAINING PROGRAM**  
**CARE AND COUNSELING CENTER OF GEORGIA**  
(For all applicants not enrolled in the Th.D. Program)

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

The Counselor Training Program offers training for students enrolled in the Th.D. program of the Atlanta Theological Association (ATA), the D.Min. in Pastoral Counseling Program of Columbia Theological Seminary, and those preparing for professional licensure. This application is for all non-Th.D. students who wish to be considered for CCCG's training program.

Applications are reviewed annually for admission beginning with the fall semester. In order to be considered for admission, the following materials must be received by CCCG by July 1. In addition, a criminal background check will be required prior to entering the program.

- a. This application form.
- b. Application fee of \$25.00. This fee is nonrefundable. Payment may be made by check (payable to CCCG) or by calling the receptionist at 404-636-1457, Option 0, and providing your credit card information.
- c. Transcript of your highest degree relevant to the practice of professional counseling.  
Unofficial copies are acceptable unless otherwise requested by CCCG.
- d. A current resume or curriculum vitae that includes your educational and employment history.
- e. A letter of interest that addresses the following:
  - Why you wish to be admitted to the training program.
  - What you wish to accomplish as a result of the training program.
  - Gifts and strengths you would bring to the program.
  - How you envision yourself conducting counseling in relation to the holistic approach utilized by CCCG in which the emotional, mental, physical, and spiritual aspects of the self are addressed.
- f. Reference forms (below) from three (3) professional references. These individuals must complete the form and return it directly to CCCG through the methods indicated on the form.

Materials may be submitted by mail or email to:

Dr. Lewis Bozard  
Director of Counselor Training  
Care and Counseling Center of Georgia  
1814 Clairmont Road  
Decatur, GA 30033  
lbozard@cccgeorgia.org

**APPLICANT INFORMATION**

**Please respond fully to each item.**

Email: \_\_\_\_\_

Phones: \_\_\_\_\_  
Work Home Cell

Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Phones:

\_\_\_\_\_ Work Home Cell

List any professional licenses or certifications you currently hold:

If you are a licensed professional, have you ever been accused of an ethical violation? (If Yes, explain on another sheet.) Yes  No

Have you ever been convicted of a felony? (If Yes, explain on another sheet.) Yes  No

In what languages other than English, if any, are you proficient to conduct counseling?

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

## REFERENCES

Please list below the individuals who will be acting as professional references on your behalf. These should be people familiar with your professional work, not friends or family members.

### 1. Reference #1:

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

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phones: \_\_\_\_\_

Work

Home

Cell

Relation to Applicant: \_\_\_\_\_

### 2. Reference #2:

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

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phones: \_\_\_\_\_

Work

Home

Cell

Relation to Applicant: \_\_\_\_\_

### 3. Reference #3:

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

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phones: \_\_\_\_\_

Work

Home

Cell

Relation to Applicant: \_\_\_\_\_