

DIRECTORY INFORMATION FORM (DIF)

Please type or print clearly using a pen. BCD #, first name, middle initial & last name MUST be filled in to process.

A. PERSONAL INFORMATION

1. *BCD # _____
2. *Title _____
(e.g. Dr., Rev., Capt. not Mr. or Ms.)
3. *First Name _____
4. *M.I. _____
5. *Last Name _____
6. *Suffix _____ (e.g. Jr.)
7. Gender Female Male
8. Social Security # _____ - _____ - _____
9. Date of birth ____/____/____
 mth. day yr.
10. ✓if active member of the Uniformed Services
11. *Other languages spoken (list below)

12. E-mail address (internal use only)
_____ @ _____

B. ADDRESS(es)

1. *Directory Listing Address (also used for ABE mailings)

Name of location (if applicable, e.g. The Counseling Center) _____

Street _____ Apt/Suite _____

City _____ State _____ Zip _____ - _____ Country _____
County _____

Telephone: (_____) _____ - _____ x _____

FAX: (_____) _____ - _____

E-mail address (for Directory publication): _____ @ _____

Non-USA Telephone: _____ - _____ - _____

Check the box that applies:
Home Home/Office Office
Home Home/office Office

2. OPTIONAL Mailing Address (To receive ABE mailings at an address different from the one listed above; WILL NOT BE PUBLISHED.)

Name of location (if applicable, e.g. The Counseling Center) _____

Street _____ Apt/Suite _____

City _____ State _____ Zip _____ - _____ Country _____
County _____

Telephone: (_____) _____ - _____ x _____

FAX: (_____) _____ - _____

Non-USA Telephone: _____ - _____ - _____

Check the box that applies:
Home Home/Office Office
Home Home/Office Office

C. EMPLOYMENT

1. *Current Place(s) of Employment

a. Name of Employer/Practice: _____
From ____/____ To Present
 mth. yr.

2. Do You Currently Engage in Private Practice?

Yes No

EMPLOYMENT continued

b. Name of Employer/Practice: _____
 From ____ / ____ To Present
 mth. yr.

3. *Previous Place of Employment

Name of Employer/Practice: _____
 From ____ / ____ To ____ / ____
 mth. yr. mth. yr.

D. STATE LICENSURE/CERTIFICATION

<p>1. *State _____ *Type/Initialism _____ (e.g. LICSW, CSW) I.D. Number _____ Exp. Date ____ / ____ / ____ mth. day yr.</p>	<p>2. * State _____ *Type/Initialism _____ (e.g. LICSW, CSW) I.D. Number _____ Exp. Date ____ / ____ / ____ mth. day yr.</p>	<p>3. *State _____ *Type/Initialism _____ (e.g. LICSW, CSW) I.D. Number _____ Exp. Date ____ / ____ / ____ mth. day yr.</p>
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E. EDUCATION

1. Graduate

a. *Social Work Degree _____ *Year Awarded _____ *College/University/Inst. _____
 City _____ State _____
 b. Other Graduate Degree _____ Year Awarded _____ College/University/Inst. _____
 City _____ State _____

2. Doctoral

a. *Social Work Degree _____ *Year Awarded _____ *College/University/Inst. _____
 City _____ State _____
 b. Other Doctoral Degree _____ Year Awarded _____ College/University/Inst. _____
 City _____ State _____

F. *CHARACTERISTICS OF PRACTICE (✓ boxes that apply)

1. Age Group(s) Served (choose 3 or fewer):

- Adolescent
- Adult
- Child
- Older Adult

3. Modalities Utilized (choose 4 or fewer):

- Conjoint
- Consultation
- Family
- Group
- Individual
- Supervision

4. Focus of Practice/Techniques/Theoretical Orientations (choose 7 or fewer, to be listed alphabetically):

- Abuse/Neglect
- Aging
- Anxiety Disorders
- Biofeedback
- Child Neglect/Abuse
- Chronic Pain
- Cognitive/Behavioral Therapy
- Critical Incident Stress Debriefing
- Developmental Disability
- Disorders associated with a medical condition
- Dissociative Disorder
- Eating Disorders
- Employee Assistance
- Family Violence
- Forensic
- HIV/AIDS
- Hypnosis
- Identity Disorders
- Impulse Control Disorders
- Interpersonal Relational Problems
- Learning Dysfunction/Disability
- Mood Disorders
- Personality Disorders
- Post Traumatic Stress Disorders
- Psychoanalysis
- Psychodynamic Psychotherapy
- Psychosomatic/Somatoform Disorders
- Psychotic Disorders
- Sexual Disorders/Dysfunctions
- Substance Abuse Disorders
- Terminally Ill/Death/Dying
- Transcultural Issues

2. Dimensions of Practice (choose 3 or fewer):

- Case Management
- Crisis Intervention
- Long-term Treatment
- Short-term Treatment
- Assessment & Referral