Section 1: Contact Information

A. Agency Lead Contact Information
Name:
Title:
Organization:
Address:
Phone number:
Email address:
Organization website:

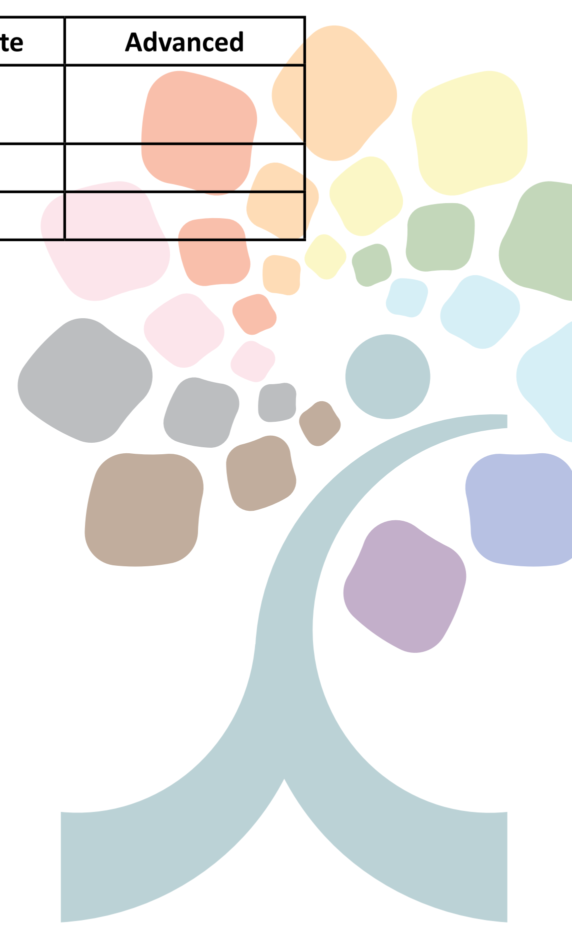
B. Therapist Contact Information (4-6 therapists who will be trained and will implement AFFIRM-Adult)

Therapist A
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No

Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			

Therapist B
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No



Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			

Therapist C
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No

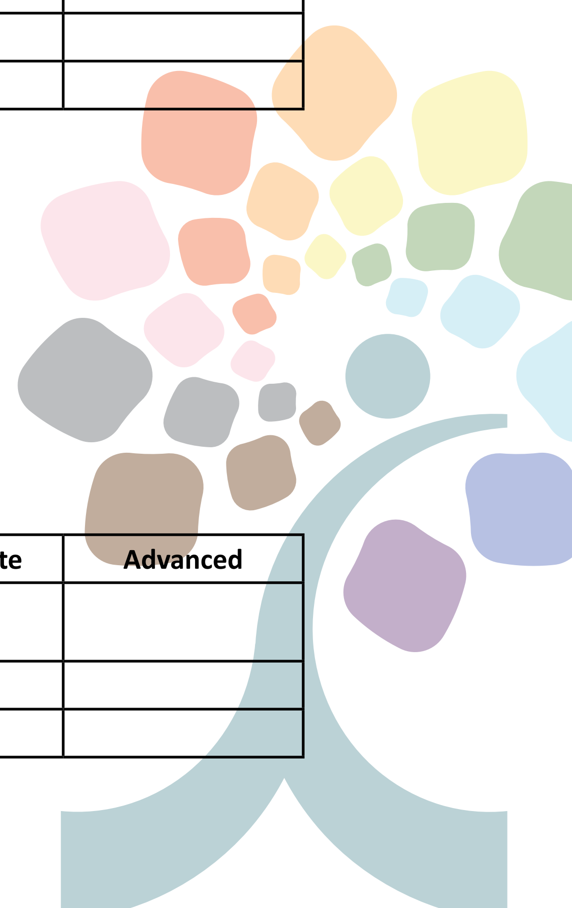
Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			

Therapist D
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No

Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			



Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			

Therapist E
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No

Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy			

Therapist F
Name:
Degree:
Title:
Role in Organization:
Phone number:
Email address:
Years of Clinical Experience:
Prior LGBTQ+ Training: Yes No

Please check the response that best describes this therapist's skill level:

Competency	Beginner	Intermediate	Advanced
Sexual Orientation & Gender Identity/Expression practice			
Cognitive Behavioral Therapy			
Group Therapy