



Association of Traumatic Stress Specialists
An International Organization
Recognizing Standards of Excellence In Response, Treatment & Services

Association of Traumatic Stress Specialists Membership Resource Directory Application

Kent Laidlaw,
CTR
President

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CTS
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Frank Shane,
CTSS, CTR

Diane Travers,
CTS

Marilyn Wooley,
CTS

In an effort to provide the public with access to ATSS members, we would like to post your name and contact information on our website.

By submitting this document, you give ATSS permission to release your information to the public.

Name: _____ Certification(s): _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Phone: _____ Website: _____

Email: _____

Area(s) of Specialty: **(Please check box(es))**

- | | |
|--|---|
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Domestic Abuse |
| <input type="checkbox"/> Combat Trauma | <input type="checkbox"/> DUI Crash Survivors and Victims |
| <input type="checkbox"/> Compassion Fatigue | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Conflict Resolution | <input type="checkbox"/> Emergency Management Firefighter/EMT |
| <input type="checkbox"/> Canine Crisis Response | <input type="checkbox"/> Eye Movement Desensitization and Reprocessing (EMDR) |
| <input type="checkbox"/> Chaplain | <input type="checkbox"/> Forensic Evaluations |
| <input type="checkbox"/> Pastoral Counseling | <input type="checkbox"/> Grief, Loss and Bereavement |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Hostage Negotiator and Barricaded Subjects |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Hypnotherapy |
| <input type="checkbox"/> Certified Trauma Responder (CTR) | <input type="checkbox"/> Marriage and Family |
| <input type="checkbox"/> Certified Trauma Specialist (CTS) | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) |
| <input type="checkbox"/> Certified Trauma Services Specialist (CTSS) | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Complex Trauma | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Cognitive Behavioral Therapy (CBT) | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Commercial Sexual Exploitation | <input type="checkbox"/> Religious and Spiritual Crises and Problems |
| <input type="checkbox"/> Corporate Victim Survivors | <input type="checkbox"/> Suicide Survivors |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Survivors of Sexual Abuse |
| <input type="checkbox"/> Critical Incident Stress Management (CISM) | <input type="checkbox"/> Trauma Rehabilitation (TIR) |
| <input type="checkbox"/> Depressive Disorders | <input type="checkbox"/> Traumatic Brain Injury (TBI) |
| <input type="checkbox"/> Dialectical Behavioral Therapy (DBT) | <input type="checkbox"/> Workplace Violence |
| <input type="checkbox"/> Disaster Preparedness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dissociative Disorders | _____ |

By signing my name, I attest that this application has been completed by me and that I have provided true and accurate information to the best of my ability.

Signature: _____ Date: _____

Please email, fax or mail this document to:

E-mail: Admin@atss.info

Fax: 973-857-0682

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