Support and Therapy Groups for Sidran Resource Database

If you run psychotherapy or processing groups for people who have experienced psychological trauma, childhood abuse, or dissociation, the Sidran Institute would like to list them in our Trauma Resources Database. To be included, please complete the questionnaire below. There is no charge for inclusion, and we thank you for the work that you do. If you need more space for any of the questions, please feel free to attach an additional sheet. Please mail completed form to 7220 Muncaster Mill Rd Suite 376 Derwood, MD 20855, or fax the form to us at 410-825-8888, or email to help@sidran.org. Thank You.

Contact Information: (* required information)

*Name of group: _____________________________________________________________
*Your Name: _________________________________
*Degree(s):_______________________________________________________________
Website: _________________________________________________________________
Company: _________________________________________________________________
Title: _________________________________
*Office Address: ____________________________________________________________
*City: _________________________________ *State: ____________________________
*Zip Code: ____________________________ *Country: __________________________
*Phone Number: __________________________ Extension: _________________________
Alternate Phone Number: __________________________ Extension: _________________________
Fax Number: ____________________________ Therapist Gender: ____________________________
*Email (for Administrative Use Only): __________________________________________
Public Email (optional): ______________________________________________________
Do you give Sidran permission to share your public email with potential clients? Yes ___ No___
*Have you previously submitted your information? Yes___ No___
Intake/Contact Person: _________________________________________________________
Philosophical Orientation (spiritual/religious): ______________________________________
*Please describe the support/therapy group: _________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Briefly state your treatment philosophy. What issues does your program focus on and how do you treat them?: ____________________________________________

________________________________________

Training and Credentials:
*Please list experience, including credentials, for running this therapy group. Please include degrees, certification, and other training: ____________________________

__________________________________________

__________________________________________

__________________________________________

*Please list memberships in professional organizations: ____________________________

__________________________________________

__________________________________________

__________________________________________

* Have you ever been censured by any professional licensing body? Yes____ No______
If yes, please specify dates and circumstances: ____________________________

__________________________________________

__________________________________________

__________________________________________

* Do you have advanced training in trauma/PTSD? Yes □ No □
Please specify training: ____________________________________________

__________________________________________

__________________________________________

*How many years of experience do you have treating trauma/PTSD? __________________
*Please describe more about your experience in treating trauma/PTSD: __________________

__________________________________________

__________________________________________

__________________________________________
* Do you have advanced training dissociative disorders/DID? Yes □ No □  
Please specify training: ___________________________________________________  
__________________________________________________________________________  

*How many years of experience do you have treating DID? ______________________  
*Please describe more about your experience in treating DID: ____________________  
__________________________________________________________________________  
__________________________________________________________________________  

* Are you affiliated with a hospital or medical center? Yes □ No □  
If yes, please name the institution and describe the relationship: ____________________________  
__________________________________________________________________________  
__________________________________________________________________________  

**Populations Served:**  

* Is your office accessible to people with physical disabilities? Yes □ No □  
* Do you treat:  
  Post Traumatic Stress Disorder? Yes □ No □  
  Dissociative Disorders? Yes □ No □  
  Dissociative Identity Disorder? Yes □ No □  
  Ritual abuse/Mind control? Yes □ No □  
  Borderline Personality Disorder? Yes □ No □  
  Sleep Disorders? Yes □ No □  
  Depressive Disorders? Yes □ No □  
  Anxiety Disorders? Yes □ No □  
  Eating Disorders? Yes □ No □  
  Self-Injury? Yes □ No □  
  Substance Abuse/Dual Diagnosis? Yes □ No □  
  Sexual Orientation/Identity Issues? Yes □ No □  
  Combat Trauma? Yes □ No □
Other Relevant Specialties (Please Describe):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Insurance Information:

*Do you have/accept: Private Insurance?  Yes ☐  No ☐

Medicare?  Yes ☐  No ☐

State Assistance?  Yes ☐  No ☐

Financial Assistance?  Yes ☐  No ☐

A Sliding Fee Scale?  Yes ☐  No ☐

Payment Plans?  Yes ☐  No ☐

Please specify which insurance plans you accept:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________