Shippensburg University

DEPARTMENT OF COUNSELING & CSP
INFORMATION DATA

Last Name:	First Name:	Middle Name:	

PERMANENT ADDRESS INFORMATION			
Street Address:			
City:	State:	Zip Code:	Phone:

TEMPORARY ADDRESS INFORMATION			
Street Address:			
City:	State:	Zip Code:	Phone:
Send mailings to temporary address until this date: (you must enter a date if using a temporary address)			

AGREEMENT TO REFRAIN FROM PRIVATE PRACTICE

I, the undersigned applicant, agree that if I am admitted to the Shippensburg University Department of Counseling, I will abide by the ethical standards of the American Counseling Association. Therefore, I agree that while I am a student, I will not provide counseling in a private practice setting.

______________________________ ______________________

Signature **Date**

Revised January 2011