Request for Inclusion on Sex-Specific Therapist Resource List

The Child Molestation Research & Prevention Institute publishes a national list of treatment providers on its website at childmolestationprevention.org. This list may also be published in other resource materials. For inclusion, sex-specific therapists and agencies must provide cognitive-behavioral treatments, refer their clients/patients to physicians for medications, if needed, and perform objective testing related to sexual interest. (The objective testing requirement is waived for practices that treat only children and teenagers.) If you would like to be considered for this resource list, please answer the following questions, sign and date the form, and return it to:
CMRPI, 1151 Harbor Bay Parkway, Suite 121, Alameda, CA 94502 or email form to contact@cmrpi.org.

1. Do you assess and/or treat (check all that apply):
   _____ Children 11 and under    _____ Adolescents/Teenagers (12-17 years old)    _____ Adults

2. Do you also treat patients/clients who have developmental disabilities?   _____ Yes    _____ No   If yes, what ages? ________________

3. Do you use cognitive behavioral treatments with your clients/patients?   _____ Yes    _____ No
   If yes, what types do you use?  ________________________________________________________________________
   ________________________________________________________________________

4. Do you support referral of some of your clients/patients to a physician for consideration of treatment with SSRIs, testosterone-reducing medications, or other drugs to assist in control of inappropriate sexual drive?
   _____ Yes    _____ No

5. Which objective tests do you use?
   _____ Penile Plethysmograph    _____ Visual Reaction Time
   _____ Polygraph    _____ None (This requirement is waived only for practices that treat children and teenagers only.)

6. Do you also treat victims and/or survivors?   _____ Yes    _____ No   If yes, what ages? ________________________________

7. Languages spoken in your practice:  ______________________________________________________________________

Name(s) (as you would like it/them listed):  ______________________________________________________________________

Name of agency or practice (if applicable):  ______________________________________________________________________

Address:  ______________________________________________________________________

City/State/Zip:  ______________________________________________________________________ Phone:  ______________________________________________________________________

Website:  ______________________________________________________________________ Email:  ______________________________________________________________________

Your type of license:  ___________________________ and your license number:  ___________________________

(Only your name, agency/practice, city, state, phone number, website, and age/type(s) of patients treated will be listed.)

I declare that the above information is true and correct and request inclusion on the CMRPI resource list as well as in the next edition of The Stop Child Molestation Book by Gene G. Abel, M.D. and Nora Harlow. This request and permission will remain in effect until revoked by me in writing.

Signature:  ______________________________________________________________________ Date:  ______________________________________________________________________