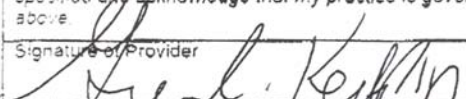


Ohio Department of Job and Family Services
**CREDENTIALS FOR PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES
 AND MEMORANDUM OF UNDERSTANDING**

Child's Name (first and last)	Date of Birth
Specify the therapy being provided to the child <input type="checkbox"/> Attachment Assessment <input type="checkbox"/> Attachment Therapy <input type="checkbox"/> Neurofeedback	
Professional Experience (please describe your professional experience with the therapy being provided to the child) Have provided attachment-focused therapy since 1990. Train nationally and internationally regarding attachment & adoption Co-authored ADOPTING THE HURT CHILD and PARENTING THE HURT CHILD Authored PARENTING ADOPTED ADOLESCENTS Neurofeedback via EEG Spectrum with ongoing supervision with <u>Sebern Fisher</u>	
Education and Training (please list all specific education and training relative to the therapy being provided to the child) BA MSSA Ph.D. Annual participation at ATTACH Conference	
Professional Credentials LISW-S Ph.D.	
Name of Provider (first and last) <u>Gregory C. Keck, Ph.D.</u>	
Name of Practice/Office <u>Attachment and Bonding Center of Ohio</u>	
Street Address of Practice/Office <u>12608 State Road - Suite 1</u>	
City, State and Zip Code <u>Cleveland OH 44133</u>	(Area Code) Telephone Number <u>440-230-1960 #2</u>
Ohio License # <u>4354</u>	Licensing Board <u>Social Worker Board Ohio State Board of Psychology</u>
<small>I, the undersigned, certify that the therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-23-16 "Special treatment and safety measure," 5122-26-16.1 "Mechanical restraint and seclusion," 5122-26-16.2 "Physical restraint" and 5122-26-16.3 "Aversive behavioral interventions and plans." I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.</small>	
Signature of Provider 	Date <u>7/1/09</u>