

Vermont Secretary of State
Office of Professional Regulation
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www.vtprofessionals.org

Board of Psychological Examiners/Allied Mental Health Practitioners

Disclosure Document for Non-licensed and Non-certified Psychotherapists

First Name Kathryn	Middle Initial	Last Name Duncan
		Registration # 097-0132586
Previous Name(s) (Maiden)		

Formal Education	Name of Institution: Union Institute & University
	Dates Attended: 2/2015 - 8/2017
	Degree(s) awarded, if any: Masters in ART Clinical Counseling
Formal Education	Name of Institution:
	Dates Attended:
	Degree(s) awarded, if any:

Training	Title of Training Program: Vermont Zero Suicide Academy
	Names & Addresses of trainer and/or institution:
	Dates Attended: 5/24/2023 - 5/25/2023
	Subject and/or content: decrease S.I & support individuals
	Credential(s) awarded, if any:

Training	Title of Training Program: PESI EMDR
	Names & Addresses of trainer and/or institution:
	Dates Attended: 4/29/24 - / /
	Subject and/or content: EMDR - A Rapid, Safe, & Proven
	Credential(s) awarded, if any:

Training	Title of Training Program:
	Names & Addresses of trainer and/or institution:
	Dates Attended:
	Subject and/or content:
	Credential(s) awarded, if any:

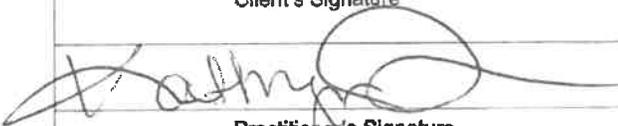
Experience	Description of Practice:	S.W in both Residential & In hospital	
	Location: City/State/Zip	Brattleboro Retreat	
	Duration:	10/1/2018 - 1/1/Current	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input checked="" type="radio"/> YES	<input type="radio"/> NO
How often?	M-F 2 hours days Monthly		
Experience	Description of Practice:	School Based Clinician	
	Location: City/State/Zip	HORS - Brattleboro	
	Duration:	2/1/2018 - 4/1/2019	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input checked="" type="radio"/> YES	<input type="radio"/> NO
How often?	Weekly		
Experience	Description of Practice:		
	Location: City/State/Zip		
	Duration:	____/____/____ - ____/____/____	
	Status:	<input type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input type="radio"/> YES	<input type="radio"/> NO
How often?			

Scope of Practice	Therapeutic Orientation:	Person centered - DBT - CBT
	Area of Specialization:	Adults & children
	Treatment Methods:	inpatient; outpatient, residential

My practice is also governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online at <http://vtprofessionals.org/>

Client's Disclosure Confirmation

My signature acknowledges that I have been given the professional qualifications and experience of (Name, Name), a listing of actions that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.

Client's Signature	Date
	7/2/2025
Practitioner's Signature	Date