

Vermont Secretary of  
State  
Office of Professional  
Regulation  
89 Main Street, 3<sup>rd</sup> Floor  
Montpelier VT 05620-  
3402



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[www.vtprofessionals.org](http://www.vtprofessionals.org)

# Board of Psychological Examiners/Allied Mental Health Practitioners

## Disclosure Document for Non-licensed and Non-certified Psychotherapists

First Name <u>Robin</u>	Middle Initial	Last Name <u>Dentles</u>
Previous Name(s) (Maiden)		Registration # <u>097.0135479</u>

Formal Education	Name of Institution: <u>Antioch University</u>
	Dates Attended: <u>8, 29, 22 - PRESENT</u>
	Degree(s) awarded, if any: <u>Master of Science in Clinical Psych</u>
Formal Education	Name of Institution: <u>Naropa University</u>
	Dates Attended: <u>8, 29, 16 - 5, 10, 19</u>
	Degree(s) awarded, if any: <u>Master of Arts in Psych</u>

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

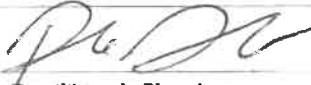
Experience	Description of Practice:	Community Services for Every1	
	Location: City/State/Zip	Buffalo NY	
	Duration:	8/22/20 - 7/15/22	
	Status:	<input checked="" type="radio"/> Full-Time	<input type="radio"/> Part-Time
	Receive supervision or peer consultation?	<input checked="" type="radio"/> YES	<input type="radio"/> NO
	How often?	Weekly	
Experience	Description of Practice:	Longmont CORE	
	Location: City/State/Zip	Longmont CO	
	Duration:	7/13/20 - 5/27/20	
	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:	Hopelight Clinic	
	Location: City/State/Zip	Longmont CO	
	Duration:	8/20/19 - 2/1/20	
	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	

Scope of Practice	Therapeutic Orientation:	Existential, integrative
	Area of Specialization:	SPMI
	Treatment Methods:	therapy, testing

**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
	7/3/25
Practitioner's Signature	Date