All sections of this public disclosure must be completed, even if one puts not applicable. All pages need to be included as well.

Every document below is part of public disclosure and must be given to each client no later than the third office visit and must be submitted to this Office as part of your public disclosure.

Board of Allied Mental Health Practitioners

Disclosure Document for Non-licensed and Non-certified Psychotherapists

First Name Ryan	Middle Initial N	Last Name Ross
Previous Name(s) (Maiden)		

Formal Education	Name of Institution:	Webster Vienna Private University
	Dates Attended:	08 / 01 / 2019 - 05 / 01 / 2021
	Degree(s) awarded, if any:	Masters in Psychology with an emphasis in Counseling
Formal Education	Name of Institution:	Susquehanna University
	Dates Attended:	08 / 01 / 2014 - 05 / 01 / 2018
	Degree(s) awarded, if any:	Bachelors in Psychology

Training	Title of Training Program:	
	Names & Addresses of trainer and/or institution:	
	Dates Attended:	___/___/___ - ___/___/___
	Subject and/or content	
	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:	
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:	Social worker therapist at the Brattleboro Retreat - Adult LGBTQ+ inpatient
	Location: City/State/Zip	Brattleboro VT 05301
	Duration:	02 / 10 / 2025 - / / Present
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	weekly
Experience	Description of Practice:	Social worker therapist at the Brattleboro Retreat Adult inpatient
	Location: City/State/Zip	
	Duration:	08 / 01 / 2022 - 08 / 01 / 2023
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	weekly
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	/ / - / /
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	

Scope of Practice	Therapeutic Orientation:	DBT / CBT
	Area of Specialization:	Adults - inpatient mental health
	Treatment Methods:	DBT / CBT

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.

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
Practitioner's Signature Date