PRETRIAL DIVERSION
THERAPIST/COUNSELOR CERTIFICATION FORM

Instructions for participants: Complete this form and return it to the address below within 30 days of your orientation into the Pretrial Diversion Program.

I, _____________________________, hereby certify that I have enrolled in counseling, therapy, or education as indicated below. I understand that failure to complete this counseling, therapy, or education will result in my termination from the Pretrial Diversion Program. I further understand that knowingly submitting false, fictitious, or fraudulent statements herein may subject me to criminal prosecution under OCGA § 16-10-20.

I have enrolled in (check all that apply):

☐ Anger management counseling.
☐ Family Violence (Batterers) Intervention Program.
☐ Drug/alcohol counseling.
☐ Theft and Shoplifting Offenders Program.

Therapist/Counseling/Education Agency:
Name: __________________________________________________________
Address: _________________________________________________________
____________________________________________________________________
Telephone: (____)______-___________

Date of first scheduled session: ________________________________

This the _________ day of ___________________________, 20__________

Participant’s signature ____________________________________________
____________________________________________________________________

Cobb County District Attorney’s Office e-mail: pretrialdiversion@cobbcounty.org
Attention: Pretrial Diversion Program Fax: 770-528-3035
70 Haynes St., Marietta, GA 30090