



Irish Association for Counselling and Psychotherapy

ACA (Australian Counselling Association) Recognition of Accreditation Application Form

NOTICE TO APPLICANTS: Please use CAPITAL LETTERS throughout your application.

You are advised to read the IACP Code of Ethics and Practice and the Accreditation section of the IACP website www.iacp.ie before completing this form. Please consider printing these pages double sided if the option is available to you.

Please return this completed form to: The Accreditation Supervisor, IACP, First Floor, Marina House, 11-13, Clarence Street, Dun Laoghaire, Co. Dublin.

PERSONAL DETAILS

Gender: M / F

Date of Birth (dd/mm/yy): _____

Surname: _____ Title: _____

Forename: _____ Employer / Occupation: _____

Address: _____

Phone: _____ (Home) _____ (Mobile)

Email: _____

Occupation: _____

Date first accredited as counsellor by ACA: _____

Level of accreditation: Level 3 Level 4

Date of current letter of authentication: _____

Please enclose a copy of your Certificate of Accreditation and current Letter of Authentication.

Have you ever had a complaint upheld against you by the ACA? Yes No

Have you ever been a member of another Counselling / Psychotherapy Association? Yes No

If yes, state the name of the association:

CURRENT SUPERVISOR'S PERSONAL DETAILS

Name: _____

Address: _____

Phone: _____ (Home) _____ (Mobile)

Email: _____

IACP Accredited Supervisor: Yes No

Supervisor's Accrediting Body: _____ Membership Number: _____

Signature: _____ Date: _____

Please note that according to IACP Supervision Requirements, Supervision must be completed with IACP, BACP, IAHIP or ACI Accredited Supervisor.

PROFESSIONAL LIABILITY INSURANCE

Name of Insurance Company:

Policy Number: _____ Expiry Date (dd/mm/yy): _____

GARDA VETTING

I confirm I have applied for IACP Garda Vetting

Signature of Applicant: _____ Date: _____

IACP - ACA Recognition of Accreditation Agreement Terms and Conditions

1. ACA will notify IACP of all Accredited Members who join ACA through this Agreement for the purposes of statistical monitoring.
2. IACP will notify ACA of all Accredited Members who join IACP through this Agreement for the purposes of statistical monitoring.
3. Where a Counsellor/Psychotherapist is granted accreditation on the basis of this Agreement, all the benefits normally associated with each organisations accreditation status will be conferred upon the applicant.
4. A Counsellor/Psychotherapist who takes advantage of this Agreement will be required to ensure that they are working within the applicable Code of Ethics and Practice / Ethical Framework and will be subject to the respective organisations Professional Conduct Procedure.
5. Where a complaint is made against a Counsellor / Psychotherapist, the complaint will be dealt with by the appropriate organisation.
6. Both organisations will inform the other of membership being withdrawn or regarding any sanctions given to members as outcomes of Complaints Procedures / Fitness to Practice Investigations / Garda (Police) Vetting being unsuccessful, depending on the current legislation of both countries.

I have read, understand and agree to the above Terms and Conditions of the IACP – ACA Recognition of Accreditation Agreement. I confirm that I agree to be bound by the IACP Memorandum and Articles of Association and to abide by the IACP Code of Ethics and Practice.

I confirm the information I have supplied is correct and true. I understand that any inaccurate or false information or omission of material information shall render this application invalid.

I understand that IACP membership and accreditation may be revoked if Garda Vetting application is not approved by IACP. Non-compliance with IACP Garda Vetting process will result with IACP Accreditation being revoked.

I confirm that I am in current, appropriate supervision in accordance with IACP supervision requirements and will continue to do so for the duration of my accreditation with the IACP.

Signature of Applicant: _____ Date: _____