



*Irish Association for Counselling and Psychotherapy*

# First Time Accreditation Application Form

**NOTICE TO APPLICANTS:** Please use CAPITAL LETTERS throughout your application. If insufficient space is provided on this form, you may attach extra pages, numbering each additional answer.

You are advised to read the Accreditation Section of the website [www.iacp.ie](http://www.iacp.ie) and the 'IACP Code of Ethics and Practice' before completing this form. Please consider printing these pages double sided if the option is available to you.

Return this form, together with your Supervisor Report Form(s) and a copy of your core course certificate signed by your Supervisor to: The Accreditation Department, IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin, or scan and email to [accreditation@iacp.ie](mailto:accreditation@iacp.ie)

## 1. PERSONAL DETAILS

Gender: \_\_\_\_\_ Date of Birth (dd/mm/yy): \_\_\_\_\_

Membership Number: \_\_\_\_\_ Title: \_\_\_\_\_

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_ Mobile Phone Number: \_\_\_\_\_

Employer / Occupation: \_\_\_\_\_

## 2. CORE COURSE. Evidence of successful completion of core course must be submitted with application

Course Provider Name: \_\_\_\_\_

Full Course Title: \_\_\_\_\_

Address of Course Provider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of course (if different to above): \_\_\_\_\_

Course Days: weekday or weekend?

Start Date  
(DD/MM/YYYY)

End Date  
(as per course documentation)  
(DD/MM/YYYY)

If your course end date is more than five years ago, please address the reasons for this in a cover letter (see <https://iacp.ie> for details)

Was this an IACP Accredited Course? Yes ☐ No ☐

**If No please complete the Non-IACP Accredited Course details on pages 5 - 7 and submit with your application along with all supporting documentation.**

### 3. 450 CLIENT HOURS BREAKDOWN

To be recorded after IACP training requirements are met, (100/120 hours, min. of 2 academic years, 50 hours personal therapy). Supervision must take place at least monthly with a minimum of one supervised session to every 10 client contact hours post qualification and one to every five during training. Totals at the bottom of the page must be calculated.

Please use a separate row for each year of practice.

Date from:	Date to:	Total Client Hours within this time:	Did Supervision take place monthly (✓ or X):	Number of individual supervision hours within this time	Number of group supervision Hours within this time	Name of Supervisor
01/01/2015 Example	31/12/2015 Example	120 Example	✓ Example	12 Example	0 Example	Joe Bloggs Example
TOTALS						

Ratio per year = Client hours divided by Supervision hours:

Of the total client hours above, how many were with:

Groups/couples/families

Clients under the age of 18

Client hours completed remotely

Client hours completed face-to-face

Please explain any gaps in your client work here (include additional pages if required):

#### 4. YOUR PHILOSOPHY OF COUNSELLING

This should describe your personal and theoretical counselling / psychotherapy philosophy and show how it is congruent with your current counselling / psychotherapy practice (between 400 and 500 words).

SAMPLE

## 5. SUPERVISION

Name, address and qualification(s) of current Supervisor

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Qualifications: \_\_\_\_\_

5 (a) Were any of your supervisors also course staff on your core training? Yes \_\_\_\_\_ No \_\_\_\_\_

## 6. COMMITMENT TO PROFESSIONAL AND PERSONAL DEVELOPMENT

Please provide a summary of CPD completed during the last 12 months. Please do not submit CPD logs with this application unless requested. Information pertaining to CPD can be found on the IACP website [www.iacp.ie](http://www.iacp.ie)

*10 hours/points of CPD from the 12 months prior to submitting must be documented below, 3 of which can be supervision received*

## 7. PROFESSIONAL CONDUCT

7.1 Have you ever been refused accreditation by any other professional body? Yes \_\_\_\_\_ No \_\_\_\_\_  
(if yes, include cover letter with application)

7.2 Have you ever had your accreditation withdrawn by any other professional body? Yes \_\_\_\_\_ No \_\_\_\_\_  
(if yes, include cover letter with application)

## 8. FIRST TIME ACCREDITATION REQUIREMENTS

### PROFESSIONAL LIABILITY INSURANCE

I confirm that I have adequate current and on-going professional indemnity insurance: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Expiry Date (dd/mm/yy): \_\_\_\_\_

### IACP GARDIA VETTING

I confirm my IACP Garda Vetting is valid and current / I have applied to IACP for Garda Vetting Yes \_\_\_\_\_ No \_\_\_\_\_

### MEMBERSHIP VERIFICATION

I consent to IACP sharing my membership status with third parties such as members of the public, employers and health insurers for the purposes of membership verification

Yes \_\_\_\_\_ No \_\_\_\_\_

### IACP JOURNAL PUBLICATION

If successful, I wish for my name and County to be published in the quarterly IACP Journal Yes \_\_\_\_\_ No \_\_\_\_\_

### 9.SIGNATURE OF CURRENT SUPERVISOR

I confirm that to the best of my knowledge, the above details are true and I believe the applicant to be a Counsellor/ Psychotherapist worthy of IACP Accreditation.

Signature of Supervisor: \_\_\_\_\_

Date: (dd/mm/yy): \_\_\_\_\_

### 10.SIGNATURE OF APPLICANT

I wish to apply for IACP Accreditation. I have read the IACP Code of Ethics and Practice and I agree to abide by it. 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.

Signature of Applicant: \_\_\_\_\_

Date: (dd/mm/yy): \_\_\_\_\_

*If your core training was not accredited by IACP, please continue to complete your application overleaf.*

### Application Checklist:

1. Completed all fields incl. signature lines
2. Included a copy of your core training signed by your supervisor
3. If applying more than five years after qualifying from your core training, you have included a cover letter to provide the Accreditation Committee with further context to assess your application
4. Page 2 "450 CLIENT HOURS BREAKDOWN" has been recorded correctly ie. One row per calendar year of practice – if you had more than one supervisor in any calendar year, please record both of their names in the same cell and combine their supervision totals together
5. A supervisor report for every supervisor that you worked with while accruing your 450 client hours
6. If you have completed a non-IACP accredited course, you have included a course handbook/prospectus/brochure with the relevant information highlighted and recorded in the checklist overleaf.
7. Incomplete applications will be returned
8. Completed applications can be emailed to [accreditation@iacp.ie](mailto:accreditation@iacp.ie) or posted to:  
The Accreditation Department, IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin

## NON IACP ACCREDITED COURSE DETAILS

If your core course was not IACP Accredited when you completed it, please complete this table

**Supporting Documentation from the course provider must be submitted to demonstrate the following requirements were met.**

Criteria	Was this criterion met?	State where in the documentation (page and paragraph number) provided it shows this requirement was met and highlight accordingly. Applications where this is not clearly indicated will be returned to sender
1. Core course must be a minimum of NFQ Level 8 (or international equivalent) and a minimum of 4 years full or part time in duration and not less than 500 hours of student contact.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Minimum of 100 hours of supervised individual client contact hours* (120 for courses starting September 2020)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Ratio of 1 hour of supervision for every 5 client contact hours (1:8 ratio accepted for courses starting before 2015)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. 70% in-person min. 500 hours of class (student/tutor) contact hours including skills, theory & self-development (Documentation provided must include: <ul style="list-style-type: none"> <li>• A breakdown of these hours (skills training/theory/self-development etc.)</li> <li>• Module descriptors and online delivery</li> <li>• Assessment methods used)</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. A detailed study of 1 theoretical model of Counselling/Psychotherapy with an introduction to others	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Min. 70% in-person 50 hours of personal therapy (letter from therapist accepted)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Applicants must be assessed prior to being accepted onto the course	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Certificate of successful completion of the course must be issued to students	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. In-house group supervision facilitated by course provider	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. Was your external supervision during training individual - NB. min. of 70% to be in-person	Yes <input type="checkbox"/> No <input type="checkbox"/>	
11. Was your core course completed entirely with course provider named above? If No please provide details.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. Was there any credit allowance or Approved Prior Learning (APL) granted as part of your core course? If Yes please provide details.	Yes <input type="checkbox"/> No <input type="checkbox"/>	

\* Client work refers to specific one-to-one counselling/psychotherapy relationships with clients over 18 years of age

**NON IACP ACCREDITED COURSE DETAILS (Continued)**

**Supporting Documentation from the course provider must be submitted to demonstrate the following requirements were met.**

Criteria	State where in the documentation (page and paragraph number) provided it shows this requirement was met and highlight accordingly. Applications where this is not clearly indicated will be returned to sender
13. Qualification of staff. Name at least two core tutors and their qualifications and professional bodies	
14. Please list the Accreditation of external supervisor(s) during training?	
15. Please list the Accreditation of personal therapist(s) during training?	

**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.**

Signature of Applicant: \_\_\_\_\_ Date: (dd/mm/yy): \_\_\_\_\_

IACP gather and process your personal information in accordance with the relevant Irish Data Protection legislation and other applicable laws. We process your personal information to meet our legal, statutory, and contractual obligations and to provide you with our products and services. We will hold your data securely and will never disclose your data to another organisation without your consent, unless required to do so by law. In addition, we only ever retain personal information for as long as is necessary. Should we engage the services of third party service providers in order to process your data, such processing is done in compliance with the applicable legislation, and within the terms of a formal, written contract. Please do not send originals of documents as material will be destroyed in conjunction with IACP's retention period.