Please note: This is not a valid application form.

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 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 Secretary, IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin.

1. PERSONAL DETAILS

Gender: M / F

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

Membership Number: M ________________________

Title: ______________________

Surname: ____

First name: __________________________________

Address: ____

SAMPLE

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Email: ____

Mobile Phone No: ____________________________

Employer / Occupation: ____

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

2.1 Course Provider

Full Course Title: ____

Address of Course Provider: ____

____

Location of course (if different to above): ____________________________

____

Course Days: weekday or weekend

Start Date: ________________________________

End Date: ________________________________

Was this an IACP Accredited Course? Yes No

If No please complete the non IACP Accredited Course details on page 5 and page 6 and submit with your application along with all supporting documentation.

3. CLIENT WORK AFTER TRAINING

Supervision must take place at least monthly with a minimum of one supervised session to every 10 client contact hours. Explain on a separate page any gaps in your client work / contact hours. Totals at the bottom of the page must be calculated. Use a separate line for each Supervisor and place of practice. Use a separate line for each year of practice.

Date from: (dd/mm/yy)	Date to: (dd/mm/yy)	Number of Individual Adult client hours within this time	Number of Group / Couples / Family client hours within this time if applicable	Total Client Hours within this time	Supervision hours per month within this time	Total Supervision Hours within this time	Place of Practice: Organisation name or private practice	Name of Supervisor And state if it was 1-to-1 or group supervision
	TOTALS							

SAMPLE

Ratio: Client hours to Supervisor hours (divide Client Hours by Supervisor Hours):_________

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:

____

____

Any other current Supervisor: ____________________

6. COMMITMENT TO PROFESSIONAL AND PERSONAL DEVELOPMENT
The following is optional: Please give details of present commitment to professional and personal development such as training courses, individual counseling or therapy, study, reading, support group etc.

____

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SAMPLE

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____

7. PROFESSIONAL CONDUCT

7.1 Have you ever been refused accreditation by any other professional body? Yes / No

7.2 Have you ever had your accreditation withdrawn by any other professional body? Yes / No

8. FIRST TIME ACCREDITATION REQUIREMENTS

PROFESSIONAL LIABILITY INSURANCE

I confirm that i have adequate current and on-going professional indemnity insurance.

(initial)

Name of Insurance Company: ____________________

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

IACP GARDA VETTING

I confirm my Garda Vetting is valid and current. ☐

(initial)

Signature of Applicant: ____________________

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: ____________________

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: ____________________

NON IACP ACCREDITED COURSE DETAILS

If your core course was not IACP Accredited when you completed it, please complete page 5 and page 6 of this application form and submit them with your application.

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

2.2 List the entry requirements:

SAMPLE

2.3 What was the Length of the course?

2.4 Qualification of staff. Name at least two core tutors and their qualifications and professional bodies

2.5 Name the Main Theoretical Approach:

List other theories studied:

2.6 Number of class (student / tutor) contact hours:

Documentation provided must include:

- A breakdown of these hours (skills training/theory/self-development etc.)
- Module descriptors
- Assessment methods used

2.7 Total number of individual client contact hours:

2.8 Total number of individual supervision hours:

Ratio of supervision to client hours:

2.9 Total Number of individual personal therapy hours:

Was your core course completed entirely with course provider named above? Yes / No
If No please provide details.

Was there any credit allowance or Approved Prior Learning (APL) granted as part of your core course? Yes / No
If Yes please provide details.

NON IACP ACCREDITED COURSE CHECKLIST

Criteria	Was this criterion met?	State where in the documentation provided it shows this requirement was met and highlight accordingly.
1. Course length must be a minimum of two years full or part time	☐ Yes ☐ No	
2. Minimum of 100 hours of supervised individual client contact hours	☐ Yes ☐ No	
3. Ratio of 1 hour of supervision for every 8 client contact hours	☐ Yes ☐ No	
4. 450 hours of class (student/tutor) contact hours including skills, theory & self-development	☐ Yes ☐ No	
5. A detailed study of 1 theoretical model of Counselling/Psychotherapy with an introduction to others	☐ Yes ☐ No	
6. 50 hours of personal therapy	☐ Yes ☐ No	
7. Applicants must be assessed prior to being accepted onto the course	☐ Yes ☐ No	
8. Certificate of successful completion of the course must be issued to students	☐ Yes ☐ No	

SAMPLE

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:** ____________

Documents will be destroyed after an appropriate period of time as per the IACP Retention policy. Do not send any original documents unless specifically requested. Keep a copy of any application forms/correspondence you send to IACP for your own records.