Irish Association for Counselling and Psychotherapy

Re-Instatement of Accreditation 2-7 years lapsed - **Part A**

Cancelled between 2 years and 7 years:
Complete **Part A,** submit to the Accreditation Department and then **Part B** of this form after holding Pre-Accredited membership for 12 months. The applicant must hold Pre-Accredited Membership for the 12 months immediately prior to submitting **PART B** of this form.

The applicant must:

1. Meet Pre-Accredited Member supervision requirements for the 12 months prior to submitting **PART B** of this form (1:10)
2. Log 30 hours of CPD in the 12 months prior to submitting **PART B** of this form
3. Have current Professional Liability Insurance
4. Must undergo Garda Vetting

How to apply:
Part A of this form should be completed when applying for the Re-Instatement of Accreditation if your membership has been cancelled for between 2 years and 7 years. This should be accompanied by the processing fee of €100.

Once you meet all the above requirements please complete **Part B** of this application form and return it to the IACP office. All applications are at the discretion of the Accreditation Department and Re-instatement of Accredited Membership is not guaranteed.

Please complete using CAPITAL LETTERS and return to the IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin or scan and email to accreditation@iacp.ie

DECLARATION OF APPLICANT
I apply for Re-Instatement of my Accredited Membership. 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 all applications are at the discretion of the Accreditation Department and Re-instatement of Accredited Membership is not guaranteed.

Signature of Applicant:_____ Date: _____

1. PERSONAL DETAILS

Membership No: _____ Title:_____

Surname:_____Forename:_____

Email: _____

2. DATE YOUR ACCREDITED MEMBERSHIP WAS CANCELLED (dd/mm/yy): _____

Reason your accredited membership was cancelled:

_____

_____

Why you wish to be re-instated: _____

_____

_____

Signature: _____ 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.

Irish Association for Counselling and Psychotherapy

Re-Instatement of Accreditation Application Form - **Part B**

1. PERSONAL DETAILS

Surname:_____ Title: _____

Forename: _____

Address: _____

_____

_____

Phone:_____(Home)_____(Mobile)

Email:_____

Membership No: _____

Employer / Occupation: _____

_____

Work Address: _____

_____

_____

Work Phone No: _____

2. CLIENT EXPERIENCE IN LAST 12 MONTHS

Supervision must take place at least monthly with a minimum of 1 hours of supervision to every 10 hours of client contact work. If you practice in more than 1 location please provide the details on a separate sheet. Explain on a separate page any gaps in your client work.

Place of Practice e.g. Organisation or private practice (Name and Location): _____

_____

From (dd/mm/yy): _____ To (dd/mm/yy): _____

Your Role _____

Nature of Client Work (Individual / group counselling etc.): _____

Total Client Hours: _____

Supervisor (Name & Accrediting Body): _____

_____

Group Supervision Hours: _____ Individual Supervision Hours: _____ Total Supervision Hours: _____

For Group Supervision:
How often are the sessions?_____ How many Supervisees in the group?_____Length of group sessions? _____

Ratio of Supervision Hours to Client Contact Hours: _____

I confirm that this ratio of supervision to client contact hours has been met.

Signature of Applicant:_____ Date: _____

3. SUPERVISION IN THE LAST 12 MONTHS (To be completed by Supervisor)

If you have changed supervisor or have more than one supervisor, then photocopy this page as necessary and complete a page for each supervisor used in the last 12 months.

Name of Supervisor: _____

Supervisor Accrediting Body & Membership Number: _____

Date of initial Supervisor Accreditation (dd/mm/yy): _____ Date and period of current Supervisor Accreditation (dd/mm/yy): _____

Address: _____

_____

Contact Phone Number: _____ Email Address: _____

Start of Supervision contract (dd/mm/yy): _____ End of Supervision contract (dd/mm/yy) or Current: _____

Frequency & length of supervision sessions: _____

I recommend the reinstatement of the applicants IACP Accreditation: ☐ Yes ☐ No

If No please state reason: _____

_____

_____

Additional Comments: _____

_____

_____

I have read the applicant's application form which, to the best of my knowledge, is correct.

Signature of Supervisor: _____ Date: _____

4. CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Please submit details of the required number of hours of CPD activities that relate to *counselling /psychotherapy* and have impacted on your professional practice over the past 12 months. CPD activities may include further training (given and received), seminars, work-shops, publishing articles, published research, committee work, etc. [N.B. This list is not exhaustive].

CPD ACTIVITY: brief description of the activity	No. of hours

I am satisfied that the above activities have contributed to the personal and professional development of the applicant.

Signature of Supervisor: _____ Date: _____

On a separate sheet of paper describe in more detail <u>one</u> of the above activities, relevant to your area of practice, which you have listed.

Provide reasons for choosing the activity with reference to your practice and show how the activity has influenced your practice. Remember to include the date of your activity.

5. PROFESSIONAL LIABILITY INSURANCE

Name of Insurance Company: _____

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

6. DECLARATION OF APPLICANT

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