



*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](http://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 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).

## PERSONAL DETAILS

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

Surname: \_\_\_\_\_ Title: \_\_\_\_\_

Forename: \_\_\_\_\_

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: \_\_\_\_\_

Do you wish for your name and County to be published in IACP's quarterly journal as a newly

Accredited member of IACP: Yes \_\_\_\_\_ No \_\_\_\_\_

## CURRENT SUPERVISOR'S DETAILS

Name: \_\_\_\_\_ Start date of Supervision Contract: \_\_\_\_\_

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

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Mobile)

Supervisor's Accrediting Body (IACP/BACP/IAHIP): \_\_\_\_\_ Member No.: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

### PROFESSIONAL LIABILITY INSURANCE

Name of Insurance Company:

\_\_\_\_\_

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

### GARDA VETTING

I understand that IACP Garda Vetting is required as part of the application process (IACP Garda Vetting invite will follow)

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

### ONGOING MEMBERSHIP VERIFICATION

I give my consent to IACP to share 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 - 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 and membership verification.
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: \_\_\_\_\_

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. 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.