IRISH ASSOCIATION OF HUMANISTIC

AND INTEGRATIVE

PSYCHOTHERAPY(IAHIP)

CONFIDENTIAL

APPLICATION FOR ACCREDITED MEMBERSHIP

UNDER BYE LAW 11

During Covid 19 – there are new Addendum forms which need to be completed if you worked by video or phone during the pandemic on the website for details.

Please do not include information which is not required with your application

This form can be hand written or typed

Original Applications cannot be returned, so please keep a copy for your own reference

[The bracketed numbers refer to sections of Bye Law 11 that may be helpful but are not intended to replace a study of the bye law as a whole.]

Applicant's Name:

_____

1. Personal Details

1.1 Name: _____ **Previous Name:** _____

1.2 Address: _____

_____

_____

_____

1.3 Phone No: _____

1.4 E-mail: _____

1.5 Age range: 18 – 25 ☐ **25 – 40** ☐ **40 – 55** ☐ **55 & over** ☐

2. Educational/Training Background: [3.1 & 4]

Please include copies of Degrees and Certificates listed below.
For non-recognized courses please include a fully completed and signed off:
'**IAHIP Confirmation of Breakdown of Training Hours Form'**

Start Date	End Date	Training Institution	Full Course Title	NFQ Level	Awarding Body

3. Postgraduate-level Psychotherapy Training [3.1]

This is Postgraduate level training in Humanistic and Integrative Psychotherapy that matches with Bye Law 11 criteria.

3.1 Name of Phase 1 Training Body:

_____

3.2 Phase 1 Training Course Title:

_____

3.2.1 Phase 1 Training Course Dates: [3.1 & 4]

____/_____/_____ ____/_____/_____
Start date **Graduation date**

3.2.2 Name the relevant undergraduate degree (min. 3 years) or equivalent, prior to psychotherapy training :[3.1]

_____

3.3 Completion of Phase 1 Training:
Did you complete the course in full? [2.1(i)] _____

Did the Training Body declare you as having successfully completed the course? [2.1(i)] _____

3.4 Is this an IAHIP recognised course?
If the answer is yes, please skip section 4 and move on to section 5 _____

(Phase 1 of all IAHIP recognised courses has already been assessed and found to meet necessary criteria, therefore graduates of such courses do not need to complete section 4.)

4. Phase 1 - Details of the Phase 1 Psychotherapy Training: [4]

Please supply from your training provider a course schedule and an IAHIP Confirmation of Breakdown of Training Hours document, demonstrating compliance with IAHIP course requirements and linking those requirements to the course schedule.

4.1 Combined total of Theory and Group Learning Hours: [4.1.1] _____

4.2 Total Number of Theoretical Hours only: [4.2] _____

4.2.1 Did this content include: **Yes or No**

(a) A primary focus on humanistic & integrative modality _____

(b) An understanding of other psychotherapeutic approaches _____

(c) Human development throughout the lifespan _____

(d) Theories of change _____

(e) Assessment and intervention _____

(f) Social issues _____

(g) Psychopathology _____

(h) Research _____

(i) Professional issues (ethics, law and networking) _____

4.2.2 Total Number of Group Learning Hours: [4.3] _____

(Not including any hours counted under Personal Psychotherapeutic Experience in Section 7 below) [4.3.1]

Did this include: [4.3]

(a) Skills practice & training rooted in experiential learning & primarily informed by modalities of psychotherapy that are humanistic & integrative in nature. [4.3(i)] _____

(b) Personal development and exploration of one's own process (including experiential training workshops) which may include group work within the course which engages & explores one's own process in a group setting. [4.3(ii)] _____

4.3 Phase 1 Supervisor/s: [7.3a or b or 7.3.1] **Please read these sections of the bye law fully before completing this section.** (To be completed in regard to each supervisor during Phase 1) Please note that supervision of clinical practice whether Phase 1 or Phase 2 must be face-to-face to be eligible to be counted towards Accreditation i.e. no Skype, Phone, Facetime or other virtual applications. Should exceptional circumstances arise with your supervisor, where face-to-face is not possible for a short period, these circumstances must be clearly documented and included in the application for consideration [6]. From June 2020 a minimum frequency of monthly supervision is required [7.1].

Supervisor 1:

4.3.1 Name of Supervisor: _____

4.3.2 Supervision Accreditation & Qualifications: _____

_____

4.3.3 Period of Supervision: _____ _____

Start date **End date**

4.3.4 Breakdown of Supervision Hours

Individual Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____

Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____

Number of Clinical Practice hours related to this Supervision _____

Number of group members [7.1.1] _____

(The group shall not exceed four supervisees. Clear equivalence within a different structure will, in certain circumstances, be acceptable.)

4.3.5 Phase 1 Ratio of Supervision Hours to Client Hours [7.1] _____

4.3.6 Was this your training supervisor? [7.3.2] _____

(The supervisor with a reporting and assessment responsibility to your training course)

4.3.7 Are any of the hours above non face to face Supervision? [6] _____

Yes/No

Number of hours non face to face: _____

If you answered yes above, please outline the exceptional circumstances which arose for this to happen:

_____

_____

4.3.8 Did you work with this Supervisor in any other capacity? [7.3c] _____

Yes/No

If yes above, please provide details.

_____

_____

Confirmation by Supervisor:

Supervisors Name:

_____ _____

Print Name **Hand Signature**

(Note: a Digital Signature is not acceptable.)

Supervisor 2:

4.4.1 Name of Supervisor: _____

4.4.2 Supervision Accreditation & Qualifications: _____
_____

4.4.3 Period of Supervision: _____ _____
Start date **End date**

4.4.4 Breakdown of Supervision Hours
Individual Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____
Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____
Number of Clinical Practice hours related to this Supervision _____

Number of group members [7.1.1] _____
(The group shall not exceed four supervisees. Clear equivalence within a different structure will, in certain circumstances, be acceptable.)

4.4.5 Phase 1 Ratio of Supervision Hours to Client Hours [7.1] _____

4.4.6 Was this your training supervisor? [7.3.2] _____
(The supervisor with a reporting and assessment responsibility to your training course)

4.4.7 Are any of the hours above non face to face Supervision? [6] _____
Yes/No

Number of hours non face to face: _____
If you answered yes above, please outline the exceptional circumstances which arose for this to happen:
_____
_____

4.4.8 Did you work with this Supervisor in any other capacity? [7.3c] _____
Yes/No

If yes above, please provide details.
_____
_____

Confirmation by Supervisor:

Supervisors Name:

_____ _____
Print Name **Hand Signature**
(Note: a Digital Signature is not acceptable.)

5. Supervised Clinical Practice (Phases 1 & 2)

To Date (Phases 1 & 2 combined):

Please note that supervision of clinical practice whether Phase 1 or Phase 2 must be face-to-face to be eligible to be counted towards Accreditation i.e. no Skype, Phone, Facetime or other virtual applications. Should exceptional circumstances arise with your supervisor, where face-to-face is not possible for a short period, these circumstances must be clearly documented and included in the application for consideration [6]. From June 2020 a minimum frequency of monthly supervision is required [7.1,7.2]. There must be a clear distinction between line management and Clinical Supervision. Therefore, for accreditation purposes, an applicant who received supervision from a line manager cannot count this towards accreditation.[7.3c]

5.1 Total Clinical Practice hours to date: [3.4, 6 & 6.1] _____

5.2 Total number of Clinical Supervision Hours to date: [3.5, 7] _____

5.2.1 Do the total clinical supervision hours include any didactic Supervision in Phase 1? [7.1.2] **Yes or No** _____

If yes, how many? [7.1.2] _____

Phase 1:

5.3 Total Clinical Practice hours in Phase 1: [6.1, 6.3] _____

5.3(a) Clinical Practice Start Date [6.2] ___/___/___

(Note: Please read Bye Law section fully as, if your Psychotherapy training started on/after Sept 2018, Clinical practice within the training course must not take place in the first two years of training.

If your Psychotherapy training started before Sept 2018 and your clinical practice began before the end of Year 2. You must provide evidence of one of the following when submitting your application:

1) Evidence from the training institute to show that you had prior knowledge and experience as a clinical practitioner **or**

2) Evidence from your training institute that states the special condition for earlier clinical practice that is relevant to you.

5.4 Total number of Clinical Supervision Hours in Phase 1: [3.4, 6.1, 6.3] _____

Breakdown of Supervision Hours:

Individual Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____

Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [6.1, 6.3, 7, 7.1.1] _____

Number of Clinical Practice hours related to this Supervision _____

Number of group members [7.1.1] _____

(The group shall not exceed four supervisees. Clear equivalence within a different structure will, in certain circumstances, be acceptable.)

5.5 Phase 1 Ratio of Supervision Hours to Client Hours [7.1] _____

Changing to Phase 2 supervisor: [7.3.2]

During the Phase 2 post-course practicum (pre-accreditation) period, until the applicant has completed in aggregate **300** hours of supervised clinical practice during Phases 1 and 2 of psychotherapy training, supervisees are free, subject to sub-clause 7.3, to be supervised by a supervisor who had been their training supervisor during Phase 1 or who had had a significant role in their Phase 1 training. At that juncture, a period of three months shall be allowed to enable the graduate supervisee seek out a new supervisor.

Please note that supervision of clinical practice whether Phase 1 or Phase 2 must be face-to-face to be eligible to be counted towards Accreditation i.e. no Skype, Phone, Facetime or other virtual applications. Should exceptional circumstances arise with your supervisor, where face-to-face is not possible for a short period, these circumstances must be clearly documented and included in the application for consideration [6]

There must be a clear distinction between line management and Clinical Supervision. Therefore, for accreditation purposes, an applicant who received supervision from a line manager cannot count this towards accreditation.[7.3c]

From June 2020 a minimum frequency of monthly supervision is required [7.1, 7.2]

5.6 When did you complete 300 supervised clinical practice hours? [7.3.2, 6.3]
(if not completed during phase 1) **Date: ___/____/____**

5.7 Did you complete a minimum of 150 supervision of clinical practice hours during the combined phases 1 and 2? [7, 3.5] **Yes or No** _____

5.8 When did you commence Phase 2 supervision with a supervisor who was not your training supervisor and who did not have a significant role in your training?
[7.3.2] : **Start Date**: ___/____/___

Phase 2:

5.9 Phase 2 Post-course Practicum Dates: [3.2] **Start Date** _____ **End Date** _____

5.10 Total Clinical Practice Hours in Phase 2: [6.1] _____

5.11 Total number of Clinical Supervision Hours in Phase 2: [7.2] _____

Breakdown of Supervision Hours:
Individual Supervision Hours: [6.1, 7.2.1] _____
Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [7.2.2] _____
Number of Clinical Practice hours related to this Supervision _____
Number of group members [7.2.2] _____
(The group shall not exceed four supervisees.)

5.12 Phase 2 Ratio of Supervision Hours to Client Hours [7.2] _____

5.13 Total number of clinical practice hours in 12 months preceding application for accreditation: [6.1] _____

5.14 Within the 500 hours, supply evidence from your supervisor of working with at least one client for 40 hours or more. The rest of the hours can be a mixture of long-term and short-term work.

6.0 Phase 2 Supervisor/s

- **Supervised psychotherapy practice with peers does not qualify.**
- **A spouse or equivalent partner does not qualify as a Supervisor. If you had more than one Supervisor since completion of training, please enclose a letter of confirmation of Total Number of Hours of Supervision from the other Supervisor/s.**
- **All supervisors to confirm details given in their section below.**
- **A detailed Supervisor's Report must be submitted for your supervisor during the twelve months prior to application. Please note: that you must have been with the same Supervisor in the 12 months preceding application. The accreditation Committee would have discretion to review this under exceptional circumstances.**
- **Please note that supervision of clinical practice whether Phase 1 or Phase 2 must be face-to-face to be eligible to be counted towards Accreditation i.e. no Skype, Phone, Facetime or other virtual applications. Should exceptional circumstances arise with your supervisor, where face-to-face is not possible for a short period, these circumstances must be clearly documented and included in the application for consideration [6]**
- **There must be a clear distinction between line management and clinical supervision. Therefore, for accreditation purposes, an applicant who received supervision from a line manager cannot count this towards accreditation. [7.3c]**
- **From June 2020, a minimum frequency of monthly supervision is a requirement [7.2].**

Please Supply details of each Phase 2 supervisor: [7.3a or b or 7.3.1]

Supervisor 1:

6.1 Name of Supervisor: _____

6.2 Supervision Accreditation & Qualifications: _____
_____

6.3 Period of Supervision: _____ _____
Start Date **End Date**

6.4 Frequency of Supervision: _____

6.5 Breakdown of Supervision Hours:
Individual Supervision Hours: [6.1, 7.2.1] _____
Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [7.2.2] _____
Number of Clinical Practice hours related to this Supervision _____

Number of group members: [7.2.2] _____
(The group shall not exceed four supervisees.)

6.6 Was this supervisor your allocated training supervisor during Phase 1, or did they have a significant role in your training? [7.3.2] ☐ **Yes** ☐ **No**
If yes, please provide further information:
_____
_____

6.7 Are any of the hours above non face to face Supervision? [6] _____
Yes/No

Number of hours non face to face: _____
If you answered yes above, please outline the exceptional circumstances which arose for this to happen:

_____
_____
_____

6.8 Did you work with this Supervisor in any other capacity? [7.3c] _____
Yes/No

If yes above, please provide details.

_____
_____

Confirmation by Supervisor:

Supervisors Name: _____

_____ _____
Print Name **Hand Signature**
(Note: a Digital Signature is not acceptable.)

Supervisor 2 (if applicable):

6.1 Name of Supervisor: _____

6.2 Supervision Accreditation & Qualifications: _____
_____

6.3 Period of Supervision: _____ _____
Start Date **End Date**

6.4 Frequency of Supervision: _____

6.5 Breakdown of Supervision Hours:
Individual Supervision Hours: [6,1, 7.2.1] _____
Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [7.2.2] _____
Number of Clinical Practice hours related to this Supervision _____

Number of group members: [7.2.2] _____
(The group shall not exceed four supervisees.)

6.6 Was this supervisor your allocated training supervisor during Phase 1, or did they have a significant role in your training? [7.3.2] ☐ **Yes** ☐ **No**

If yes, please provide further information: _____
_____
_____

6.7 Are any of the hours above non face to face Supervision? [6] _____
Yes/No

Number of hours non face to face: _____
If you answered yes above, please outline the exceptional circumstances which arose for this to happen:
_____
_____
_____

6.8 Did you work with this Supervisor in any other capacity? [7.3c] _____
Yes/No

If yes above, please provide details.
_____
_____

Confirmation by Supervisor:

Supervisors Name: _____

_____ _____
Print Name **Hand Signature**
(Note: a Digital Signature is not acceptable.)

Supervisor 3 (if applicable):

6.1 Name of Supervisor: _____

6.2 Supervision Accreditation & Qualifications: _____
_____

6.3 Period of Supervision: _____ _____
Start Date **End Date**

6.4 Frequency of Supervision: _____

6.5 Breakdown of Supervision Hours:
Individual Supervision Hours: [6.1, 7.2.1] _____
Number of Clinical Practice hours related to this Supervision _____

Group Supervision Hours: [7.2.2] _____
Number of Clinical Practice hours related to this Supervision _____

Number of group members: [7.2.2] _____
(The group shall not exceed four supervisees.)

6.6 Was this supervisor your allocated training supervisor during Phase 1, or did they have a significant role in your training? [7.3.2] ☐ **Yes** ☐ **No**

If yes, please provide further information: _____
_____
_____

6.7 Are any of the hours above non face to face Supervision? [6] _____
Yes/No

Number of hours non face to face: _____
If you answered yes above, please outline the exceptional circumstances which arose for this to happen: _____
_____
_____

6.8 Did you work with this Supervisor in any other capacity? [7.3c] _____
Yes/No

If yes above, please provide details.
_____
_____

Confirmation by Supervisor:

Supervisors Name: _____

_____ _____
Print Name **Hand Signature**
(Note: a Digital Signature is not acceptable.)

7.0 Psychotherapeutic Experience as Client (Phases 1 & 2)

(Group and individual psychotherapy presented below should have been conducted by suitably accredited psychotherapists who worked from a humanistic and integrative perspective) [5, 5.1, 5.2, 5.2.1, 5.2.2, 5.2.3] Evidence of the hours submitted below must be included in this application for all psychotherapeutic experience.

7.1 Overall Total Psychotherapeutic Experience as Client in Training: [3.3, 5]
(Include Phase 1 and Phase 2 of training)

Breakdown of Psychotherapeutic Experience as Client:

(a) Total Phase 1 Individual Psychotherapy hours: [5.1, 5.2(i) _____

(b) Total Phase 1 Group Psychotherapy hours: [5.2(ii), 5.1] _____

(c) Total Phase 2 Individual Psychotherapy hours: [5.1] _____

(d) Total Phase 2 Group Psychotherapy hours: [5.1] _____

(e) Other forms of psychotherapeutic experience hours [5.1] _____

(This may include experiential workshops and personal feedback/tutorial sessions with trainers undertaken as part of the Phase 1 training course.)

7.2 Did you undertake group psychotherapy outside of the Psychotherapy Training Course during Phase 1: [5.2.2] _____
Yes/No

If yes, please include approval by the training organisation and confirmation that it took place while the applicant was a trainee on the training course.)

8.0 Continued Professional Development (if applicable please include photocopy of certificate)

What ongoing professional development have you undertaken since completion of training?

_____
_____
_____

8.1 Professional bodies of which you are a member (if applicable please include a photocopy)

_____
_____
_____

9.0 Personal Statement: [2(a)]

Please supply a personal statement (max 1000 words) that demonstrates how you work as a Humanistic and Integrative Psychotherapist. <u>This statement must be hand-signed by the applicant.</u>

10.0 Undertakings: [9] (please tick the relevant boxes provided)

10.1 Do you undertake:

(a) To abide by the Codes of Ethics and Practice of IAHIP? ☐ Yes ☐ No
[9 (a)]

(b) To present yourself for re-accreditation as IAHIP requires? ☐ Yes ☐ No
[9 (b)]

(c) To commit to ongoing professional development? ☐ Yes ☐ No
[9 (c)]

(d) To maintain appropriate ongoing supervision and support in accordance with IAHIP requirements? ☐ Yes ☐ No
[9 (d)]

11.0 Insurance

Professional Indemnity and Public Liability Insurance cover is a requirement for practicing as a psychotherapist. (Please enclose a copy of your current Certificate of Insurance).

12.0 Applicant's Undertakings and Declaration

[2(b)] (Please print name on line provided)

I, _____, apply for accreditation by IAHIP. I agree to abide by its Memorandum & Articles of Association, its Codes of Ethics and Practice, and to comply with its Complaints Procedures. I agree to remain covered by insurance against professional indemnity and public liability risks in my practice.

I have not been debarred by any organization for professional misconduct, and agree to notify IAHIP should I become aware of any reason why I may be subject to such an investigation in the future.

I certify that the foregoing information is correct and I understand that any false or misleading statement made on this form or in any part of the application process, or failure to disclose information relevant to this application, may result in my affiliation with IAHIP being rejected and/or any accreditation awarded being rescinded.

Hand Signed: _____ Date: ___/____/____

(Note: a Digital Signature is not acceptable)

13.0 Letter of Support

Please provide a letter of support from a professional colleague.

This does not necessarily have to be a psychotherapist but it should be someone who is familiar with how you conduct yourself in the professional arena.

<u>This letter may not be from a Trainer from your Professional Training Course and must comply with Code of Ethics provided by IAHIP.</u>

Please note: (1) the Accreditation Committee is made up of volunteers and will endeavour to process your application as speedily as possible. It is the responsibility of the applicant to supply only relevant information and to complete the application form in full. Failure to do this may cause unnecessary delay to processing the application; (2) the Accreditation Committee reserves the right, where it believes that a personal meeting with any particular applicant might assist them in processing that person's application, to call that person for a meeting with some or all members of the Committee. **[2.1(iv)]**

I, _____ fully understand the processes described above.
Applicant's Hand Signature