Details of Video Clinical Practice, Supervision Individual/Group, Personal/Group Therapy & Didactic Supervision Hours between 1st January 2021 – 30th Sept 2021.

Name of Applicant: _____

1.0 Does your insurance during this time cover you for video/phone psychotherapy? Yes or No
If yes – please include a copy of the insurance certificate/s for the relevant periods

1.1 Are any of your clients residing outside the jurisdiction? Yes or No
If yes, where did these clients reside? _____

1.2 Did you have appropriate insurance to cover these jurisdictions? Yes or No
Please include a copy of the insurance certificate/s for the relevant jurisdictions

2.0 Name of Remote Training Course completed: _____

2.1 Training Dates: (Please provide training certificate) _____ _____
Start Date **End Date**
2.2 Were you assessed for competency for video/phone psychotherapy? Yes or No
2.3 Were your clients assessed for suitability to these modes of practice? Yes or No

3.0 Does the platform you use have End-to-End encryption? Yes or No
If No give details: _____
_____

4.0 Phase 1 – Video Supervised Clinical Practice Hours 1st January 2021 – 30th Sept 2021

4.1 Supervisor Name _____

4.2 Supervisors Accreditation details: _____

4.3 Phase 1 Total Number of Video Clinical Practice Hours : _____ **(maximum 60 hours)**

4.4 Phase 1 Video Clinical Practice Dates: _____ _____
Start Date **End Date**

4.5 Please outline why Video Clinical Practice Hours in Phase 1 took place remotely:
_____
_____

4.6 Total Video Supervision Hours in Phase 1: [6.1] _____

4.7 Please outline why Video Supervision Practice Hours in Phase 1 took place remotely:
_____

4.8 Breakdown of Video Supervision Hours

4.8a Individual Video Supervision Hours: [6.1, 7.2 & subsections] _____
4.8b Duration of Sessions _____
4.8c Frequency of Individual Supervision: _____
4.8d Ratio of Supervision hours to Clinical Practice Hours[7.2] _____
4.8e Group Video Supervision Hours: [6.1, 7.2 & subsections] _____
4.8f Duration of Sessions _____
4.8g Frequency of Group Supervision: _____
4.8h Number of members in Group [7.2.2] _____
4.8i Ratio of Supervision hours to Clinical Practice Hours[7.2] _____

4.9 How many Didactic Supervision hours were completed: [7.1.2] _____

4.10 Please outline why Video Supervision Practice Hours in Phase 1 took place remotely:
_____+

Confirmation by Supervisor: please circle below

Are any of the clients of this applicant residing outside the jurisdiction? Yes or No

If yes, do they have insurance cover for the jurisdiction & modes of practice? Yes or No

Are any of the hours being submitted psychological, family or parent support hours Yes or No

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

5.0 Video Personal Therapy

5.1 Name of Personal Therapist _____

5.2 Accreditation details: _____

5.3 Dates of Video Personal Therapy _____ _____
Start Date **End Date**

5.4 Number of Video Personal Therapy Hours: _____

5.5 Please outline why Personal Therapy Hours in Phase 1 took place remotely:
_____
_____

5.6 Duration of Video Individual Therapy _____

5.7 Frequency of Video Individual Personal Therapy _____

6.0 Video Group Therapy

6.1 Name of Group Therapist _____

6.2 Accreditation Details of Group Therapist _____

6.3 Dates of Video Group Therapy _____ _____
Start Date **End Date**

6.4 Please outline why Group Therapy Hours in Phase 1 took place remotely:
_____
_____

6.5 Number of participants in Video Group Therapy _____

6.6 Duration of Video Group Therapy: _____

6.7 Frequency of Video Group Therapy: _____

Applicant's Signature/Certification:

I certify that the foregoing information is correct and I understand that any false or misleading statements 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 rescinded.

Date _____ **Print Name** _____ **Signature** _____
Hand Signature