Details of remote Clinical Practice (whether carried over from Phase 1 or all from Phase 2), Supervision (Individual/Group) Hours, Personal Therapy Hours, Didactic Supervision Hours and Group Therapy Hours between 11th Mar 2020 to 4th Oct 2020.

Name of Applicant: ____

On 11th Mar 2020 - what Year of your Training were you in ________

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

1.1 When did you start/end video/phone work during this period? _______ **Start Date** ________ **End Date**

1.2 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

1.2a Are any of your clients residing outside the jurisdiction? Yes or No
If yes, where did these clients reside? ____

1.2b 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

1.3 Did you take part in specific training for video/phone psychotherapy Yes or No

If Yes - Dates of this training _________ **Start Date** _________ **End Date**
Please provide certificate of completion in the overall Application Pack

1.4 Duration of the Training (Hours): ___________________________

1.5 Training Title : ____

1.6 Training/Certification Body (**provide copy of Cert**)_____________________________________

1.7 Were you assessed for competency for video/phone psychotherapy? Yes or No

1.8 Were your clients assessed for suitability to these modes of practice? Yes or No

1.9 Does the platform you use have End-to-End encryption? Yes or No
If No give reasons: ____
____

Section 2.0 - If you carried over Phase 1 hours to Phase 2 - Record them here, otherwise skip to Section 3 of this document

2.1 Have you a shortfall due to Covid 19 in Phase 1 Clinical Practice Hours (6.1)? _________ **Yes or No**
If No skip to relevant section below, If Yes, you must fill in the following information

2.2 If Yes - How Many Hours did you carry over? __________

2.3 From what training year are you carrying over these hours? __________

2.4 Did you have a long-standing face to face therapeutic relationship for all these clients? _____
If No, Give reasons: **Yes or No**

____
____

2.5 Phase 1 Total Number of these carried over Clinical Practice hours by Video: __________

2.6 Phase 1 Total Number of these carried over Clinical Practice hours by Phone: __________

2.7 Please outline the specific circumstances that Clinical Practice Hours were carried over into Phase 2 and completed remotely: ____
____

Supervision of Phase 1 hours in Phase 2:

Supervisor Name/Supervision credentials: ____

2.8 Total number of these video/phone Clinical Supervision Hours: [7.2] _____

2.9 Dates of this Supervision: _________ ___________
Start Date **End of Phase 1 Date**
Where min 200 hrs reached

2.10 Frequency of Supervision for these hours (Weekly/Monthly etc): ___________

Please outline the specific circumstances that these Clinical Supervision Hours moved to Video/phone?
____
____

2.11 Breakdown of Phase 1 carried over Supervision Hours

Individual Video Supervision Hours: [6.1, 7.2 & subsections] _______
Duration of Sessions _______ _____
Shortest **Longest**
Individual Phone Supervision Hours: [6.1, 7.2 & subsections] _______
Duration of Sessions _______ _____
Shortest **Longest**
Group Video only Supervision Hours: [6.1, 7.2 & subsections] _______
Number of members in Video group [7.1.1] _______
Ratio of Phase 1 Supervision hours to these Clinical Practice hours [7.1] _______

Confirmation by Supervisor:

Please confirm that all these Phase 1 hours were carried out with clients in which the applicant had a long-standing face to face therapeutic relationship? **Yes or No**
If No, please give details ____
____

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**

Supervisors Name: __________________________ _________________________
Print Name **Hand Signature**
(Note: a Digital Signature/copy of signature will not be accepted.)

2.12 How many video Didactic Supervision hrs have you completed: [7.1.2] ______

2.13 Please outline the dates & specific reasons that Didactic Supervision Hours moved to Video?

____

____

3.0 Phase 2 – Supervised Clinical Practice Hours

Supervisor Name/Accreditation: ____

3.1 Phase 2 Total Number of Video/Phone Clinical Practice Hours : _______

3.2 Phase 2 Video/Phone Clinical Practice Dates: __________ __________

Start Date **End Date**

3.3 Please outline the specific circumstances that Clinical Practice Hours in Phase 2 moved to video/phone?

____

____

3.4 Supervision of Clinical Practice hours:

Total video Clinical Practice Hours in Phase 2: [6.1] _______

Total phone Clinical Practice Hours in Phase 2: [6.1] _______

3.5 Please outline the specific circumstances that Supervision Practice Hours in Phase 2 moved to Video/Phone? ____

____

3.6 Breakdown of non face to face Supervision Hours

Individual Video Supervision Hours: [6.1, 7.2 & subsections] ______

Duration of Sessions ______ ______

Shortest **Longest**

Individual Phone Supervision Hours: [6.1, 7.2 & subsections]- _______

Duration of Sessions ______ ______

Shortest **Longest**

Frequency of Supervision: __________________

Group only Video Supervision Hours: [6.1, 7.2 & subsections] _______

Number of members in Video group [7.2.2] _______

Phase 2 Ratio of Total Supervision hours to Total Clinical Practice Hours[7.2] ______

Confirmation by Supervisor:

Please confirm that all these hours were carried out with clients in which the applicant had a long-standing face to face therapeutic relationship? **Yes or No**

If No, please give details

____

____

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**

Supervisors Name: ________________________ ________________________

Print Name **Hand Signature**

(Note: a Digital Signature/copy of signature will not be accepted.)

4.0 Video/Phone Personal Therapy

Name/Accreditation details of Personal Therapist ____

4.1 Did you take part in video/phone Individual Personal Therapy hours [5.1]: ________
Yes or No

If Yes ________________ ________________ ________________
Total Hrs Completed Remotely **Number of Phone Hours** **Number of Video Hours**

4.2 Dates of video/phone Personal Therapy ______________ ___________
Start date **End date**

What phase of your training/post training were you in when these were completed? ________

4.3 Reasons for video/phone Individual Personal Therapy: ____
____
____

4.4 Duration of video/phone Individual Therapy ______ ______
Shortest **Longest**

4.5 Frequency of video/phone Individual Personal Therapy _________

5.0 Video only Group Therapy

Name/Accreditation details of Group Therapist ____

5.1 Did you take part in Video Group Therapy hours (5.1): __________
Yes or No

If Yes How many hours were completed: _______
Number in video Group Therapy: _____________

5.2 Dates of this video Group therapy ______________ ___________
Start Date **End Date**

What phase of your training/post training were you in when these were completed? ________

5.3 Reasons for video Group Therapy: ____
____

5.4 Duration of video Group Therapy: ______

5.5 Frequency of video Group Therapy: ______

5.6 What phase were you in for this Group Therapy: ______

Applicants Signature
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
(Note: a Digital Signature/copy of signature will not be accepted.)