

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 the 5th Oct 2020 and 1st Sept 2021.

Name of Applicant: _____

On 5th Oct 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 Entire period of time related to in this document: _____
(Note: dates pre 5th Oct 2020 cannot be considered on this form) 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

(Please provide certificate of completion in the overall Application Pack) _____
Start Date End Date

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 – Up to a Max of 50 hours only – 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)? _____
If No skip to relevant section below, If Yes, you must fill in the following information **Yes or No**
(Note: These hours must be Supervised in line with (7.1) Maximum of 50 hrs can be considered here)

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 Clinical Practice hours by Video: _____

2.6 Phase 1 Total Number of these 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] _____

Phase 1 ratio of 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 or copy of signature is not acceptable.)

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

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

3.0 Phase 2 – Supervised Clinical Practice Hours due to Covid 19 Restrictions

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 was moved to remote work?

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 Video only 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 these hours were carried out with the following conditions:

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 or copy of signature is not acceptable.)

4.0 Remote 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 Number of Hrs 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 or copy of signature is not acceptable.)