

APPLICATION FOR ACCREDITED MEMBERSHIP UNDER BYE LAW 11

Addendum for Online Clinical Practice

(for applicants who were in 2nd year, 3rd year and 4th year students during the academic years of 2019-2020)


- Please do not include information which is not required with your application
- This form can be handwritten 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.]

Name of Applicant: _____


What Year/s of your Training were you in for this period?

Section 1

| | | | |
|---|--|------------|----------|
| 1.0 | Are any of the hours being submitted psychological, family or parent support hour? | | |
| 1.1 | Period of time related to in this document. | Start date | End date |
| | | | |
| 1.2 | Are any of your clients residing outside the jurisdiction? | Yes | No |
|  | If yes - please include a copy of the insurance certificate/s for the relevant period. | Check | |
| | If Yes, where did these clients reside? | | |
| | | | |

| | | | |
|---|---|-----|-------|
| 1.2b | Did you have appropriate insurance to cover these jurisdictions? | Yes | No |
|  | If Yes above, please supply policy and evidence of coverage. | | Check |
| 1.3 | Did you take part in specific training for video/phone psychotherapy? | Yes | No |
|  | If Yes above, please supply evidence | | Check |
| 1.4 | Duration of the Training (Hours) | | |
| 1.5 | Training Title | | |
| 1.6 | Training Certification Body | | |
|  | Please supply evidence | | Check |
| 1.7 | Does the platform you use have End-to-End encryption? | Yes | No |
| | If No above please give reasons | | |
| | | | |

Section 2

| | | | | |
|---|--|------------|----------|--|
| 2.0 | If you carried over Phase 1 hours to Phase 2 - Up to a Max of 50 hours only – Record them here | | | |
| 2.1 | Have you a shortfall due to COVID-19 in Phase 1 Clinical Practice Hours? [6.1] | Yes | No | |
|  | If No, skip to relevant section below. If Yes, you must fill in the following information. (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 | Phase 1 Total Number of these Clinical Practice hours by Video: | | | |
| | | Start Date | End Date | |
| | | | | |

| | |
|-----|---|
| 2.5 | Please outline the specific circumstances that Clinical Practice Hours were carried over into Phase 2 and completed remotely: |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| | |
|--|--|
| Supervisors Name (Print) | |
| Supervisor Qualification and Accreditation | |
| Signed: | |
| Date | |

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.

| | |
|---------|--|
| Signed: | |
|---------|--|

(Note: a Digital Signature is not acceptable)

| | | | |
|------|--|--|--|
| Date | | | |
|------|--|--|--|