# APCP - 3 Yearly Re-accreditation Application Form

All accredited members of APCP are required to complete the APCP annual renewal form **and** once accredited on a 3 yearly basis provide updated or additional information to support evidence of practice. Information would normally include the following:-

* Membership Status
* Garda Clearance
* Insurance
* Education
* Clinical Practice
* Evidence of supervision

**This section is to be completed by the APCP member wishing to be re-accredited:**

* **Membership Status**

**(Please tick membership status as appropriate)**

Accredited Counsellor \_

Accredited Psychotherapist \_

Accredited Supervisor \_

* I can confirm I have submitted Garda vetting to APCP \_\_\_ -
* **Insurance**

Please attach a copy of current insurance certificate.

* **Education Qualifications in Counselling and Psychotherapy.**

Please advise of any **additional** qualifications undertaken on the National Framework Qualifications or its equivalent during this accreditation period and forward a verified copy of certificates.

1. Name of Course \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Institute of Study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Year of Award \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Qualification & QQI level obtained \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Clinical Practice**

As a Clinical practitioner you are required to provide evidence of

1. clinical practice hours undertaken as a counsellor or a psychotherapist over the three year period and
2. If you are an accredited APCP supervisor -hours specifically worked as a supervisor of counsellors/psychotherapists in your practice hours engaged in supervision for both should be noted. See Appendix 1 for further detail.

* **Supervision**

Please provide a reference or references, if appropriate from your Supervisor/s using ***‘Supervisors reference form’*** as noted in appendix 2

In the event that you work as both a counsellor/psychotherapist and as a supervisor **BOTH** forms are to be filled in.

*Please note: In the event you have changed supervisor recently you will also be required to provide a reference from a supervisor who has worked with you for a minimum of 12 months.*

Appendix 1

**1.1 Clinical Practice**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type of Practice** | **Number of Hours Clinical Practice and Supervision per annum** | | | | | |
|  | **2018** | | **2019** | | **2020** | |
|  | **Clinical Practice** | **Supervision** | **Clinical Practice** | **Supervision** | **Clinical Practice** | **Supervision** |
| **Independent Practice** |  |  |  |  |  |  |
| **Voluntary Organisations** |  |  |  |  |  |  |
| **Other (please state** |  |  |  |  |  |  |
| **Clinical supervisory practice** |  |  |  |  |  |  |

This is a true and accurate statement of all clinical practice and supervision undertaken by me in the past three years.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*To be signed by those working as accredited counsellors or psychotherapists only*)

**Or (if appropriate)**

This is a true and accurate statement of all *clinical practice and supervision* undertaken by me in the past three years. I have also noted *clinical supervisory practice* hours undertaken as an accredited APCP supervisor and have recorded the specific hours I engage in supervision of same.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(To be signed by members, accredited and acting as a counsellor or psychotherapist and a supervisor*)

Appendix 2

**This Section is to be completed by your Supervisor**

**Note: Supervisors Reference**

*Supervisors are required, in their professional capacity to verify that the member has undertaken the necessary supervision related to their clinical practice.*

*The supervisor is also required to verify the suitability of the applicant for re -accreditation purposes and provide information on the members’ clinical experience.*

*Supervisors are required to have worked with the member for a minimum of 12 months and are ideally currently working with the member.*

**1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Membership Body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervision Qualification(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business/home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Awarding Body (e.g., QQI, University etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2 Supervisee (APCP Members Details)**

**Name of APCP Member** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counsellor \_\_\_\_\_**

**Psychotherapist \_\_\_\_\_**

**3 Supervisors Reference for Member**

|  |
| --- |
| 1. How long have you been supervising the person noted above, and in what capacity? |
| 1. What are the particular qualities this member brings to the field of counselling and/or psychotherapy? |
| 1. How would you describe their experience in terms of interventions used and the modality they operate from? |

**4. Supervisor declaration**

I have read and understand the requirements of membership of APCP as noted on their website and **recommend** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a suitable candidate for re-accreditation purposes as a therapist as noted in the above section regarding membership status.

I have noted my supervisee’s clinical practice hours recorded in this applicants practice log and record of supervision – appendix 1 and consider it an accurate reflection of their work.

Supervisors signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a supervisor I am a registered member of APCP Yes\_\_\_\_ No\_\_\_\_\_\_

***If you are not a member of APCP, please forward:***

* ***Proof of current registration of your counselling body***
* ***Proof of qualifications in the field of counselling/psychotherapy.***

Appendix 3

**Supervisors Reference for APCP members working as Accredited Supervisors**

*Note:*

* *To be filled in ONLY by those registered to act as accredited APCP Supervisors*
* *Supervisors are required, in their professional capacity to verify that the member has undertaken the necessary supervision related to their supervisory practice.*
* *The supervisor is also required to verify the suitability of the applicant for re -accreditation purposes and provide information on the members’ clinical supervisory experience.*
* *Supervisors are required to have worked with the member for a minimum of 12 months and are currently supervising the supervisory aspect of the member’s clinical practice.*

**2.1 Supervisors Personal Details**

Name of Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s Professional Membership Body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s Qualification(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business/home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Awarding Body (e.g., QQI, University etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.2 Members Details**

**Personal Details of APCP Member**

**Members Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Business/home address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.3 Supervisors Reference for Member**

|  |
| --- |
| How long have you been supervising the person noted above, and in what capacity? |
| What are the particular qualities this member brings to the field of counselling and/or psychotherapy? |
| How would you describe their experience in terms of interventions used and the modality they operate from? |

**2.4 Supervisor declaration**

I have read and understand the requirements of membership of APCP as noted on their website and **recommend** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a suitable candidate for re-accreditation purposes as a supervisor of therapists.

I have noted supervisory hours recorded in applicants practice log – appendix 1 and consider it an accurate reflection of their work.

Supervisors signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a supervisor I am a registered member of APCP Yes\_\_\_\_ No\_\_\_\_\_\_

***If you are not a member of APCP, please forward***

* ***Proof of current registration of your counselling/psychotherapy Association.***
* ***Proof of qualifications in the field of counselling/psychotherapy.***
* ***Proof of qualification as a supervisor.***