



# Re-Instatement of Accreditation Application Form - **Part A**

*Irish Association for Counselling and Psychotherapy*

Requirements for Re-Instatement of Accreditation depend on how long your membership has been cancelled:

- **Cancelled less than 2 months.** The individual must submit a letter detailing why they allowed their membership to lapse. This will be reviewed by the Accreditation Department and may be referred to the Accreditation Committee if deemed necessary. If membership lapses on more than one occasion, this will be reviewed by the Accreditation Committee.
- **Cancelled between 2 months and 2 years.** The individual must submit a letter detailing why they allowed their membership to lapse. They must also advise if they have seen clients during this period and if they were in Supervision. This will be reviewed by the Accreditation Department and may be referred to the Accreditation Committee if deemed necessary. If membership lapses on more than one occasion, this will be reviewed by the Accreditation Committee. The individual must undergo Garda Vetting again.  
**Cancelled between 2 years and 7 years.** The individual must hold Pre-Accredited Membership for the 12 months immediately prior to submitting **PART B** of this form  
 Meet Pre-Accredited Member supervision requirements for the 12 months prior to submitting **PART B** of this form  
 Log 30 hours of CPD in the 12 months prior to submitting **PART B** of this form  
 Have current Professional Liability Insurance  
 Must undergo Garda Vetting
- **Cancelled for 7+ years.** The individual must apply for First Time Accreditation and undergo Garda Vetting

**How to apply:**

**Part A** of this form should be completed when applying for the Re-Instatement of Accreditation if your membership has been **cancelled** for between 2 years and 7 years. This should be accompanied by the processing fee of €100.

Once you meet all the above requirements please complete **Part B** of this application form and return it to the IACP office. All applications are at the discretion of the Accreditation Department and Re-instatement of Accredited Membership is not guaranteed.

**Please complete using CAPITAL LETTERS and return to the IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin**

**DECLARATION OF APPLICANT**

I apply for Re-Instatement of my Accredited Membership. I confirm that I agree to be bound by the IACP Memorandum and Articles of Association and to abide by the IACP Code of Ethics and Practice. I confirm the information I have supplied is correct and true. I understand that any inaccurate or false information or omission of material information shall render this application invalid. I understand that all applications are at the discretion of the Accreditation Department and Re-instatement of Accredited Membership is not guaranteed.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**1. PERSONAL DETAILS**

Gender: M / F    Date of Birth (dd/mm/yy): \_\_\_\_\_    Membership No: \_\_\_\_\_

Title: \_\_\_\_\_    Surname: \_\_\_\_\_    Forename: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone (daytime): \_\_\_\_\_    Email: \_\_\_\_\_

2. DATE YOUR ACCREDITED MEMBERSHIP WAS CANCELLED (dd/mm/yy): \_\_\_\_\_

Select category or Re-instatement you are applying for:

- Cancelled for less than 2 years
- Cancelled for between 2 and 7 years

Reason your Accredited Membership was cancelled: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why you wish to be re-instated: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Documents will be destroyed after an appropriate period of time as per the IACP Retention policy. Do not send any original documents unless specifically requested.  
Keep a copy of any application forms/correspondence you send to IACP for your own records.



Irish Association for Counselling and Psychotherapy

# Re-Instatement of Accreditation Application Form - **Part B**

## 1. PERSONAL DETAILS

Gender: M / F    Date of Birth (dd/mm/yy): \_\_\_\_\_

Surname: \_\_\_\_\_ Title: \_\_\_\_\_ Membership No: \_\_\_\_\_

Forename: \_\_\_\_\_ Employer / Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

## 2. CLIENT EXPERIENCE IN LAST 12 MONTHS

Supervision must take place at least monthly with a minimum of 1 hours of supervision to every 10 hours of client contact work. If you practice in more than 1 location please provide the details on a separate sheet. Explain on a separate page any gaps in your client work.

Place of Practice e.g. Organisation or private practice (Name and Location): \_\_\_\_\_

From (dd/mm/yy): \_\_\_\_\_ To (dd/mm/yy): \_\_\_\_\_

Your Role \_\_\_\_\_

Nature of Client Work (Individual / group counselling etc.): \_\_\_\_\_

Total Client Hours: \_\_\_\_\_

Supervisor (Name & Accrediting Body): \_\_\_\_\_

Group Supervision Hours: \_\_\_\_\_ Individual Supervision Hours: \_\_\_\_\_ Total Supervision Hours: \_\_\_\_\_

For Group Supervision:  
How often are the sessions? \_\_\_\_\_ How many Supervisees in the group? \_\_\_\_\_ Length of group sessions? \_\_\_\_\_

Ratio of Supervision Hours to Client Contact Hours: \_\_\_\_\_

I confirm that this ratio of supervision to client contact hours has been met.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

3. SUPERVISION IN THE LAST 12 MONTHS (To be completed by Supervisor)

If you have changed supervisor or have more than one supervisor, then photocopy this page as necessary and complete a page for each supervisor used in the last 12 months.

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

Supervisor Accrediting Body & Membership Number: \_\_\_\_\_

Date of initial Supervisor Accreditation (dd/mm/yy): \_\_\_\_\_ Date and period of current Supervisor Accreditation (dd/mm/yy): \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Start of Supervision contract (dd/mm/yy): \_\_\_\_\_ End of Supervision contract (dd/mm/yy) or Current: \_\_\_\_\_

Frequency & length of supervision sessions: \_\_\_\_\_

I recommend the reinstatement of the applicants IACP Accreditation:  Yes  No

If No please state reason: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

I have read the applicant's application form which, to the best of my knowledge, is correct.

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

4. CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Please submit details of the required number of hours of CPD activities that relate to *counselling /psychotherapy* and have impacted on your professional practice over the past 12 months. CPD activities may include further training (given and received), seminars, work-shops, publishing articles, published research, committee work, etc. [N.B. This list is not exhaustive].

CPD ACTIVITY: brief description of the activity	No. of hours
_____	_____
_____	_____
_____	_____
_____	_____

I am satisfied that the above activities have contributed to the personal and professional development of the applicant.

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

**On a separate sheet of paper describe in more detail one of the above activities, relevant to your area of practice, which you have listed.**

Provide reasons for choosing the activity with reference to your practice and show how the activity has influenced your practice. Remember to include the date of your activity.

5. PROFESSIONAL LIABILITY INSURANCE

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiry Date (dd/mm/yy): \_\_\_\_\_

**6. DECLARATION OF APPLICANT**

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