



*Irish Association for Counselling and Psychotherapy*

# Recognition of Licensure From Regulated Countries Application Form

**IACP accepts the licensure from the following countries for the purpose of IACP accreditation:**

• United States	• Italy
• Canada (Ontario, Québec, North Brunswick, Prince Edward Island and Nova Scotia only)	• Liechtenstein
• Austria	• The Netherlands
• Finland	• Sweden
• Germany	• Switzerland
• Malta	

## **Application process**

The applicant from one of the above countries must provide the following information:

1. A copy of foreign qualifications
2. A copy of a valid license issued by the country of origin
3. Proof of setting up a contract with an Accredited Supervisor (IACP, BACP, IAHIP) in line with current Supervision criteria and attend at least one session with this supervisor before applying
4. Proof of completion of a minimum **50 hours** of Personal Therapy
5. A copy of insurance from the country where they are currently practicing
6. Current and Valid Garda Vetting/ Police Clearance certificate
7. The application fee: €155

(The applicant must ensure that all the above documents are formally translated into English by a professional translation service)

The outcome of the application for the Recognition of Licensure and Qualifications attained outside of Ireland will be dependent on individuals obtaining Garda Vetting and a Police Clearance Certificate if practicing outside of Ireland. To apply for Garda Vetting please contact IACP Garda Vetting Officer Carla Kiely at [carla@iacp.ie](mailto:carla@iacp.ie).

Please complete using CAPITAL LETTERS and return via email to [accreditation@iacp.ie](mailto:accreditation@iacp.ie) or via post to: Accreditation Department, IACP, First Floor, Marina House, 11-13 Clarence Street, Dun Laoghaire, Co. Dublin.

IACP gather and process your personal information in accordance with the relevant Irish Data Protection legislation and other, applicable laws. We process your personal information to meet our legal, statutory, and contractual obligations and to provide you with our products and services. We will hold your data securely and will never disclose your data to another organisation without your consent, unless required to do so by law. In addition, we only ever retain personal information for as long as is necessary. Should we engage the services of third party service providers in order to process your data, such processing is done in compliance with the applicable legislation, and within the terms of a formal, written contract.

If my application is successful, I would like IACP to publish my name and County in its quarterly journal?

Yes \_\_\_\_ No \_\_\_\_

### 1. PERSONAL DETAILS

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

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

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

Address: \_\_\_\_\_ Address (work): \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Phone: \_\_\_\_\_ (Mobile) Email: \_\_\_\_\_

Have you ever been refused accreditation by any other professional body? Yes ☐ No ☐

Have you ever had your accreditation withdrawn by any other professional body? Yes ☐ No ☐

*(If Yes for either of the above questions please give details on a separate sheet)*

I agree that IACP may share my membership status with third parties such as members of the public, employers and health insurers for the purpose of membership verification Yes ☐ No ☐

### 2. LICENCE DETAILS

Country of origin: \_\_\_\_\_

Licence Title: \_\_\_\_\_

Licence Provider: \_\_\_\_\_

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

\_\_\_\_\_

Telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Name of applicant as it appears on the licence: \_\_\_\_\_

Licence number: \_\_\_\_\_ Start date: \_\_\_\_\_ Expiry date: \_\_\_\_\_

*(Please provide a copy of the current licence with your application)*

### 3. QUALIFICATIONS

*Evidence of successful completion of core course must be submitted with application*

Course Provider: \_\_\_\_\_

Full Course Title: \_\_\_\_\_

Address of Course Provider: \_\_\_\_\_

\_\_\_\_\_

Location of course (if different to above): \_\_\_\_\_

\_\_\_\_\_

Date of graduation: \_\_\_\_\_

#### 4. YOUR PHILOSOPHY OF COUNSELLING

This should describe your persona / and theoretical counselling / psychotherapy philosophy and show how it is congruent with your current counselling / psychotherapy practice (between 400 and 500 words).

This image shows a single page from a notebook or ledger. It features approximately 28 thin, dark grey horizontal lines spaced evenly apart across the entire width of the page. The background is plain white, and there are no margins, text, or other markings present.

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

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

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

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

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