Membership Form

Membership No:............

Graduate Membership €80 □ Graduate with Advanced Clinical Training €80 □

Student Membership €40 □ Associate Membership €40 □ (Please tick appropriate box)

1.0 Professional Details:

Mr/ Mrs/ Ms/ Miss;

Name: ____

Address: ____

Phone (Home) ___________________________ (Work)______________________

Mobile: _____________________ Email:____________________________

Website:____

Date of Birth: ____/____/

2.0 Qualifications & Educational Background:

Name of Degree/ Diploma and/or other professional training including the Awarding Body and date awarded;

2.1 Core Training Psychotherapy:

Training Body:

Name:____

Address:____

Telephone No:____________________________________

Course Title(s):___________________________________

Start Date:____________________

End Date: ________

2.2 Qualification Type: (PLEASE TICK ALL APPLICABLE)

Higher Diploma   Masters of Science   Post Masters of Science

Year of Graduation:__________

- Did you complete the course/courses in full?   YES/NO
- If **NOT** please provide further details as to why?

3.0 Professional Development:

Members are expected to maintain a detailed log of their Supervised Practice, Personal Therapy and CPD (30 hours pa recommended).

3.1 Misconduct:

Have you ever been sanctioned by or debarred/ expelled from an organization for professional misconduct? YES/NO

If you ticked **YES** please provide further details as to why?

3.2 Insurance:

All members who are currently working within the field of Child Art Psychotherapy must obtain and continue to be covered by their own Professional Indemnity and Public Liability Insurance cover in order to qualify for membership.
Insurance Cover with…………………………………………………..Date of Renewal…………………………

3.3 Child Safety:

All members should remain up to date with National Child Safety Guidelines. Up to date training, '**Children First**: **National Guidance for the Protection and Welfare of Children**' is available on the HSE website; https://www.hseland.ie/
Please include your Children's First Training Certificate with this application form.

3.4 Applicant's Declaration:

I, ______________________________, apply for membership with ACAP. I agree to abide by its Memorandum & Articles of Association, its Codes of Ethics and Practice, and agree to comply with its Complaints Procedures. I have not been debarred by any organization for professional misconduct. I agree to remain covered by insurance against professional indemnity and public liability risks in my practice. I agree to be committed to the practice of psychotherapy, to ongoing supervision of my work and to other forms of professional development. I declare the information given in this form to be true.

Signed:__________________________ Dated:_________________________

Membership of ACAP:

Joining Date	Length of membership

Details to be featured on ACAP Website? Yes/No

I agree for ACAP to store my data in line with ACAP's GDPR and Privacy Policy Guidelines. (See Website for details) Yes/No

Payment Options

- To pay by Bank Transfer:

Please put your Full Name as 'the reason for payment' so we can identify your transfer.

Bank Details: BIC: BOFIIE2DXXX IBAN: IE05BOFI90129842926418

- To pay by PayPal:

Please log onto PayPal website or using the phone app select the ACAP account via the email address, icapsychotherapists@gmail.com

I, ________________________________, hereby confirm I have paid ACAP E_____ via Bank

Transfer/PayPal, signed, ____________________________.

Once complete please attach or scan in this membership form and relevant documents and return via email to icapsychotherapists@gmail.com

For Office Use Only:
Date Received:
Date Processed:
Outcome:
Database:
Website:
Welcome: