



Australian Association of Clinical Hypnotherapy & Psychotherapy Inc

A0036986V

Application for Accreditation as an AACHP Clinical Supervisor

1. Personal/Business Details: *Please print*

AACHP Membership Number: _____

Title: Miss: Mrs: Ms: Mr: Dr: Other _____

Given Names: _____

Surname: _____

Date of Birth: _____

Mailing Address _____

Phone:: **Home:** _____ **Work:** _____

Mobile: _____

Email: _____

Web site address: _____

Languages other than English spoken fluently?

Business/Company name: _____

Business Addresses:

(a) _____

(b) _____

(c) _____

2. Declaration:

I wish to be considered for accreditation as an AACHP Clinical Supervisor and declare that:

- a) I have been in practice as a Clinical Hypnotherapist for a minimum of five years
- b) I have completed a recognised Supervisor Training Course and/or I already have Clinical Supervisor status with another professional Clinical Hypnotherapy association and enclose a copy of relevant documentary evidence.
- c) I have read and understood the "AACHP Clinical Supervision Guidelines"
- d) My professional indemnity insurance covers me for Clinical Supervision
- e) I am not aware of any formal complaints of professional misconduct ever having been made to any professional association or registration board against me.
- f) There are no complaints of professional misconducts currently under investigation in relation to my current/past work.
- g) I have not been found guilty of any offence in Australia or overseas.
- h) I have never been refused admission to a professional association or registration board.

I understand and agree that the decision as to whether this application is approved is at the sole discretion of the AACHP Committee and that the latter is not required to communicate or assign any reason to the decision. I affirm that all the details given here are accurate to the best of my knowledge and I understand that giving false information may result in disciplinary action. I give permission for the information provided on this application form to be disclosed to relevant third parties and for my name, suburb, website and professional contact details to be included on the AACHP Website.

Signed: _____ Date: ____/____/____

Forward this completed form, together with attached copies of all relevant documents to:

AACHP Registrar
Mrs Toni Cassidy
63 Monbulk Road
Belgrave VIC 3160