


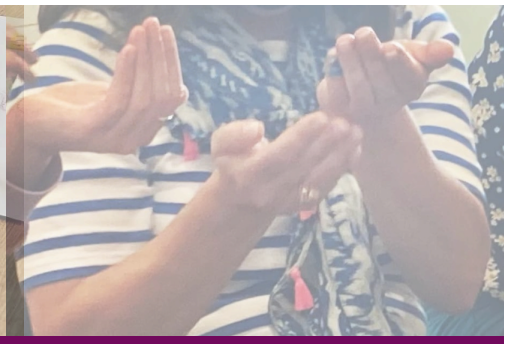

Creative Clinical Supervision Training
Application Form

Applicant's Details	
Full Name:	
Date of Birth:	
Contact Number:	
Email:	
Address:	
Postcode:	
Therapeutic Modality:	
Next of Kin:	
Next of kin contact number:	
Date form completed:	

Professional Associations & Memberships	
1st Affiliated Association/Governing Body Membership No:	
2nd Affiliated Association/Governing Body Membership No:	
3rd Affiliated Association/Governing Body Membership No:	
4th Affiliated Association/Governing Body Membership No:	

Qualifications

Qualification	Date Qualified

To complete this application form and participate in the training you have to have at least 3 years practice post qualification or for drama therapists minimum 40h personal supervision post qualification, for dance movement psychotherapists to have been on the Private Practitioners register for at least 2 years. At the time of applying you must be in active practice with a minimum of two weekly clients/client groups

Please outline here your desire to attend the Creative Supervision Training, how you hope to develop as a practitioner and why being able to supervise is important to you:

Please evidence your clinical experience over the last three years				
Clinical Context	**Client Population** (e.g. group or 1:1)	**Regularity of sessions** (e.g. weekly/1h)	**Date started – date concluded**	**Paid or Voluntary**

Please evidence your self-development, creative and movement practice over the last <u>three years</u>			
Self-development	**Movement / creative practice**	**One off/workshop** Please include date	**Regular** (weekly/monthly) date started –date concluded/ongoing

Please evidence any other employment if relevant besides clinical practice over the last <u>five years</u>					
Employer	**Job role**	**Responsibilities**	**Date started – date concluded**	**Part time or Full time**	**Paid or Voluntary**

Please evidence your Clinical Supervision over the last three years. Your supervisor must be recognized by your accredited Arts Therapy Professional Association and have had a minimum of 5 years experience as a supervisor.

Please ask your supervisor to complete the **Supervisor's Reference Form** attached with this document in support of your application.

Type of supervision	Group or 1:1	Regularity	Date started – date concluded	Name of Supervisor

Clinical Supervisor (within the last 6 months)

Full Name:	
Contact Number:	
Email:	
Address:	
Post Code:	
Affiliated Association/Governing Body Membership No:	
Qualifications and date qualified:	

Please share any more details you wish to be included in the application. These may include personal issues you wish to share with the course facilitators, which may impact your training.

Application forms for the ReLight Creative Clinical Supervision Training can be found on our website **relightcreatively.co.uk/creative-clinical-supervision-training-south-west**

CONTACT US

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ReLight

@relightcreatively

UK Council for Psychotherapy

The British Association of Dramatherapists