

National Institute of Relationship Enhancement

4400 East-West Highway, Suite 28 Bethesda, MD 20814-4501 Phone: 301-986-1479 Fax: 301-680-3756

APPLICATION FOR CERTIFICATION PROGRAM

Type of Training (Check one) Supervision only Certification Program Certification as Approved Supervisor

Content Area (Check one)

- Child-Centered Play Therapy Relationship Enhancement® Couples Therapy
 Filial Family Therapy Relationship Enhancement® Family Therapy
 Developmental Play Relationship Enhancement® Program Leader
 Other _____

Dr. Mrs.

Ms. Mr.

(Circle)

Home Address _____

Email: _____

Phone (____) _____

1. _____
Highest Degree Date Institution Field of Study (Clin. Psych., Social Work, etc.)

2. Are you licensed, certified, or registered in your state to provide mental health services independently (i.e., private practice) without supervision?

YES If YES, complete only question #4 on the back of this form.

NO If NO, you must complete questions #1-4 on the back of this form.

3. Name of Credentialing Body _____
(e.g., MD Board of Examiners of Psychologists; PA Board of Examiners for Social Work)

4. List titles and dates of workshops conducted by NIRE-Approved Instructors which you have attended; also list any previous certifications by IDEALS/NIRE which you have received.

5. Memberships in Professional Organizations (if any): _____

6. I require a supervisor who has the following special credentials: _____

7. If you would like a certain supervisor, please give name here: _____

**Mail completed application along with \$75.00 application fee
(Check made payable to NIRE) to address listed above.**

For Office Use: Fee received ___/___/___ Approval: Yes ___ No ___ Assigned to _____ on ___/___/___

Supervision Verification Form

(Items 1-3 to be completed only if applicant answered "NO" to Question #2 on front of application)

1. If you are currently a student in a graduate program in mental health, please provide the name of the university in which you are enrolled, the name of the department or program, and your program advisor's name and phone number below:

2. If you have completed a graduate degree in a mental health field but are required by your state's laws to be supervised in order to provide mental health services (i.e., you are not licensed or certified to practice independently), please provide the name of your place of employment (if applicable), and the name and phone number of your clinical supervisor below:

3. TO BE COMPLETED BY APPLICANT'S CLINICAL SUPERVISOR

The professional named on the reverse side of this form has applied to participate in a training and/or certification program offered by NIRE. The purpose of this form is to verify that the applicant is providing therapeutic services in accordance with applicable state laws while in training with NIRE, and in addition to ensure that the applicant's clinical supervisor is aware of the applicant's participation in our training program.

I affirm that the applicant has informed me of his/her intent to participate in the training and/or certification program offered by NIRE. I affirm that throughout the applicant's training with NIRE, he/she will be providing mental health services and receiving supervision for such services in accordance with applicable state laws. I recognize that the assigned NIRE staff member will serve only as a consultant to the applicant, and that the ultimate responsibility for supervision of any therapeutic services and the making of clinical decisions resides with me.

Signature Date

4. TO BE COMPLETED BY ALL APPLICANTS:

I affirm that throughout my training with NIRE, I will be providing mental health services and receiving supervision for such services in accordance with applicable state laws. I recognize that the NIRE-approved supervisor assigned to me will serve as a consultant to me in the process of being trained and/or certified in specific therapeutic skills, but that the ultimate responsibility for clinical services provided and clinical decision making remains with myself (if licensed to provide therapeutic services independently of supervision) or with my clinical supervisor (if not licensed to provide therapeutic services independently).

Signature Date