

Registration to Begin the Theraplay Certification Practicum

Registration materials required

Registration materials should be submitted to the Practicum Manager, Robin Shannon at robin@theraplay.org. The process for collecting the registration materials may vary in other countries. Please inquire with the Practicum Manager about the relevant materials in your country.

€ **Certification Practicum Registration Form - Page 2**

€ **Practicum Attestation - Page 3**

To confirm you have no criminal convictions, malpractice suits etc. this form needs to be downloaded and signed.

€ **Payment Authorization Form (if applicable) - Page 4**

Please complete this form to pay your registration fee.

To pay registration fee, visit our online store at the link below:

<https://theraplay.org/product/supervision-payments/>

Please also attached the following documents:

€ **Resume or curriculum vitae**

Description of your professional experience and should include current contact information, educational background, degrees/certificates, relevant employment history and volunteer work

€ **Professional license or professional registrations**

Confirmation of professional licensure, professional registration, or other documentation of proof of ability to legally practice in your country, state or jurisdiction. *(For registrants from the United Kingdom, registration with a professional body such as HCPC or BACP will meet this requirement.)*

€ **Current Professional Indemnity Insurance**

Confirmation that you have your own professional indemnity insurance or that your organization covers you for your Theraplay-informed work.

€ **Written permission from your supervisor at work (if applicable) – Page 5**

If employed by an agency or organization, written permission from your supervisor, line manager or director of the agency, to use your work for the practicum.

Certification Practicum Registration Form

Registrant Contact Information:

First Name: _____ Last Name: _____

Degrees/Credentials: _____

Preferred Mailing Address: _____

City: _____ State: _____ Country: _____

Preferred Email Address: _____

Preferred Phone: _____

How did you hear about the certification program? (Please check one)

Word of Mouth

Referral

Level One Training

Email from Practicum Manager

I am registering for (Please check all that apply):

Theraplay Practicum: Individual Dyadic

Group Theraplay Practicum: Individual

Name of Theraplay Supervisor (if assigned): _____

If supervisor has not been assigned, please indicate name or credentials if you have a preferred supervisor below:

Note: Please ensure the name provided in the above contact information reflects the name that you would like on any certificates you may receive throughout this program. Please also ensure the provided mailing address reflects where you would like your certificate shipped upon completion of a practicum level..

Theraplay® Certification Practicum Attestation

I understand that by registering to join the Theraplay® or Group Theraplay® practicum, I am indicating that I agree to the following statements:

- I am in compliance and will abide by Theraplay Service Mark guidelines, calling my work “Theraplay informed practice” until I fully complete the Theraplay practicum upon which I can call my work “Theraplay.” (See <https://theraplay.org/the-theraplay-institute/service-mark/>)
- I will use Theraplay® within the confines of my professional role, credentials and the ethics of any professional bodies of which I am a member.
- I may be required to do additional supervision sessions beyond the minimum to ensure my skills are at the required level for certification. If it is determined that additional supervision is necessary I understand that I will have to pay additionally for these supervision sessions.
- I do not have a criminal record that may prejudice the interests of children and families
- I have not been dismissed from employment on the grounds of professional misconduct or lack of competence
- I have not been refused membership of a professional body in a related field on the grounds of professional misconduct or lack of competence.
- I will keep The Theraplay Institute informed of any changes to my circumstances, either professionally or in relation to my personal character (including any conviction or caution that you are required to disclose).
- I am covered by Professional Indemnity and Public Liability insurance either personally or by my employer’s policies.
- I have the proper Consent to Videotape forms on file for each client whose video I submit for Theraplay supervision or consultation including the following statement:

“Video will be used by the therapist in his/her treatment of my family (for example, we review portions of sessions with you to enhance positive treatment outcomes) and for supervision with a qualified Theraplay supervisor.”
- If there are any updates or changes to my contact information, resume/CV, professional licensure/registration and proof of liability insurance, I will notify the Theraplay Institute.

Practicum Student Full Name

Practicum Student Signature

Date

Payment Authorization Form

Please complete the information below:

I _____ hereby authorize The Theraplay Institute to initiate credit entries to my credit card account in the amount determined below. I understand that this authorization will remain in effect until the balance of the agreed total is paid in full. I certify that I am an authorized user of this credit card and will not dispute these transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form. I understand that I will be charged a \$50 fee if my credit card is declined within the required 3 days of the notice.

I understand that upon beginning the practicum level all fees are non-refundable. If for some reason I am not able to begin the practicum I may be eligible for a refund minus a non-refundable \$200 processing fee. Any refund request must be in writing and approved by the practicum manger. This applies to all levels of the practicum.

The Theraplay Institute is authorized to charge this card for: (please check all that apply)

Theraplay Practicum:

____ Foundational Level (*Circle one*): Individual - Dyadic
____ Intermediate Level
____ Final Level

Group Theraplay Practicum:

____ Foundational Level
____ Final Level

Total Amount: _____ Theraplay Supervisor Name: _____

Billing Address: _____ Phone #: _____

City, State, Zip: _____ Email: _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ Security Code _____

SIGNATURE _____ **DATE** _____

Sample Permission Letter

ABC Foster and Adoption Agency

Dear Practicum Manager,

As the direct clinical supervisor of **Jane Doe** at **ABC Foster and Adoption Agency**, I can confirm that **Jane Doe** has permission to join the Theraplay Practicum and use Theraplay as a therapeutic modality as appropriate with her clients.

Kind regards,
Agency Supervisor