

Candidate Application Form

Code:

Course Title:

Name:.....

Mailing address:

Billing address:

E-mail:

Please complete and tick (✓) primary contact number:

- Admin contact:.....
- Emergency contact:.....
- Fax:.....
- Home phone:.....
- Mobile phone:.....
- Other:.....

Do you have any special requirements please detail below:

Languages spoken:

Please tick (✓)

- | | | | |
|----------------------|--------------------------|---------------------|--------------------------|
| Arabic: | <input type="checkbox"/> | Bengali: | <input type="checkbox"/> |
| Chinese: (Cantonese) | <input type="checkbox"/> | Chinese: (Mandarin) | <input type="checkbox"/> |
| French: | <input type="checkbox"/> | German: | <input type="checkbox"/> |
| Greek: | <input type="checkbox"/> | Hindi: | <input type="checkbox"/> |
| Italian: | <input type="checkbox"/> | Japanese: | <input type="checkbox"/> |
| Korean: | <input type="checkbox"/> | Latin: | <input type="checkbox"/> |
| Malay-Indonesian: | <input type="checkbox"/> | Polish: | <input type="checkbox"/> |
| Portuguese: | <input type="checkbox"/> | Punjabi: | <input type="checkbox"/> |
| Russian: | <input type="checkbox"/> | Sign language: | <input type="checkbox"/> |
| Spanish: | <input type="checkbox"/> | Tagalog: | <input type="checkbox"/> |
| Vietnamese: | <input type="checkbox"/> | | |

Please indicate (✓) your ethnic origin

- | | | | |
|-----------------|--------------------------|-----------------|--------------------------|
| White European: | <input type="checkbox"/> | Black European: | <input type="checkbox"/> |
| African: | <input type="checkbox"/> | Afro Caribbean: | <input type="checkbox"/> |
| Asian: | <input type="checkbox"/> | Chinese: | <input type="checkbox"/> |
| Other: | <input type="checkbox"/> | | |

Membership of associations:

Please tick (✓)

BABCP:	<input type="checkbox"/>	UKRC:	<input type="checkbox"/>
BACP:	<input type="checkbox"/>	UKCP:	<input type="checkbox"/>
EMDR:	<input type="checkbox"/>	BPS:	<input type="checkbox"/>
Royal College of Psychiatrists:	<input type="checkbox"/>	FDAP:	<input type="checkbox"/>

Placement Locations:

1. Location Name:.....
 Street:.....
 City/Town:.....
 Post Code:.....
 Country:.....
 Contact person:.....
 Contact telephone:.....
 Fax number:.....

2. Location Name:.....
 Street:.....
 City/Town:.....
 Post Code:.....
 Country:.....
 Contact person:.....
 Contact telephone:.....
 Fax number:.....

3. Location Name:.....
 Street:.....
 City/Town:.....
 Post Code:.....
 Country:.....
 Contact person:.....
 Contact telephone:.....
 Fax number:.....



Liability:

Licence/Registration:

£
Expiry date:
Carrier/Insurer:

Type:
Expiry:

Please tick (√)

- I would like details about myself to be held on the Saunders Clinic database and have completed the attached database form. I understand that such information will be used solely by Saunders Clinic and securely stored.

Signed:.....

Date:.....

Saunders Clinic Undertaking:

I, undertake to accept responsibility
(insert name)
for the following:

- To maintain, at my own cost, comprehensive policies for professional indemnity and public liability insurance to the minimum level stipulated by Saunders Clinic from time to time and to produce copies of my policy when required by Saunders Clinic.
- To ensure I receive supervision to the minimum level required by BACP or equivalent professional body.
- To pay any fees due within 30 days of invoiced date.
- To advise Saunders Clinic of any changes to my circumstances (i.e. practice address, home address, contact telephone numbers, availability).

Signed:.....

Name:.....
(please print)

Dated:.....

I am willing for Saunders Clinic to pass on my name and telephone number to other affiliates/clients for training referrals.

Please circle as appropriate:

Y / N – clients

Y / N - other