

**Clinical Associate Membership - Application Form**

All fields must be completed

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| Personal details and contact information |
|  |
| Last name |  | First name(s) |  | Date of Birth |
|  |
| Postal address:  |  | Postcode |
|  |
|  |
| Main contact number |  | Alternative contact number |  | Email address: |
|  |
| Professional Qualification and Standing |
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| Please provide the following details in respect of your professional accreditation/registration: |
|  |
| Membership number |  | Date of registration/accreditation |
|  |
| Details of the practice label under which you are accredited (e.g. psychoanalytic psychotherapist, psychodynamic psychotherapist, group analyst, child and adolescent therapist etc) |
| Please attach a copy of your membership certificate confirming the above information |
|  |
| I confirm there are no formal complaints or disciplinary actions pending or proved against me | If there are formal complaints please attach details on a separate sheet |
| Yes | No |
|  |
| Professional referees |
|  |
| Please provide details of two referees one of whom should be a UKCP, BPC, ACP or BACP registered supervisor: |
|  |
| Name and contact details |  | Name and contact details |
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| Professional insurance or proof of employer’s insurance |
|  |
| Please provide details of your current professional insurance |  | Please attach a copy of your insurance certificate or evidence of employer’s cover |
|  |
| Current and previous Organisational Member |
|  |
| Please provide details of any other Psychotherapy Organisational Memberships including your current Organisational Member |
|  |
| **Organisation1 (current)** |  |  |  |  |  |
| Name |  | Contact address |  | Member from date: | Member to date: |
|  |
| **Organisation2** |  |  |  |  |
| Name |  | Contact address |  | Member from date: | Member to date: |
|  |
| Details of your accredited training |
|  |
| Training Organisation/Institution conferring accreditation: |  | Title of the course: |
|  |
| Course start date: |  | Graduation date: |  | Please attach a copy of your graduation certificate |
|  |
| Please give your reasons for wishing to join FiP and what you think you can contribute  |
|  |
| Please include a copy of your CV with your application |
|  |
| Before submitting your completed application please read and sign the Statement of Good Standing and Membership Commitment |

Please return this completed form and any supporting documents to administrator@fip.org.uk, or to

FiP Administrator, 66 Smirrells Road, Hall Green, Birmingham B28 0LB. Telephone 07984 348318

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| FeesFees for application are £75. This is a one off payment and is non-refundable. We will be unable to consider your application until the application fee has been received.Payment can be made via bank transfer to: Santander, Sort Code: 09-06-66, Account: 41352982 or by PayPal to Administrator@fip.org.uk An invoice can be arranged through PayPal to make it easier to pay via this route. Please let the administrator know if you require this.Upon successful application the administrator will contact you with details of the annual membership fee required. The annual fee in respect of clinical associate membership is £85 per annum and will be pro-rated based on your joining date (our membership year runs from 1st April). |

**Statement of Good Standing and Membership Commitment**

I confirm that by signing this form:

* I am in good standing with other professional organisations of which I am or have been a member (see note below)
* There are no formal complaints or disciplinary actions pending or proved against me
* I hold appropriate professional indemnity insurance
* I have professional executorship arrangements in place in respect of my practice
* I agree to abide by FiP’s Code of Ethical Professional Practice

Note: Submission of an application implies permission for FiP to confirm with other organisations declarations made within it. If there are formal complaints please give details on a separate sheet. Failure to disclose complaints or disciplinary actions will lead to termination of FiP membership.

I confirm that by signing this form, following my acceptance as a Clinical Associate Member, I commit to maintaining my current professional registration and to advising FiP of any alteration in my clinical practice status or issues that might affect my professional good standing. I accept that if my registered status lapses my membership of FiP will be cancelled and all fees forfeited.

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| --- | --- | --- |
| Signature |  | Date: |

**Data Protection Statement**

The information which you give when completing your application will be used in accordance with the General Data Protection Regulations for the sole purpose of processing and maintaining your membership of FiP and communicating relevant information to you. Your information will not be shared with any third parties. It will be kept securely and for no longer than necessary. Submission of this form indicates your agreement to these Data Protection terms.

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| **Checklist:**  |  |
| All required elements of the form have been completed |  |
| BPC/BACP registration certificate enclosed |  |
| Details of formal complaints or disciplinary actions pending or proven (if applicable) |  |
| Proof of appropriate insurance |  |
| Details of professional executorship arrangements |  |
| Graduation Certificate of accredited training  |  |
| Copy of CV |  |
| Statement of good standing read and signed |  |
| Payment of relevant application fee |  |