



CANADIAN COLLEGE OF PROFESSIONAL COUNSELLING PRACTITIONERS

Application for Advanced Designation Advanced Counselling Practitioner (ACP)

Please return completed Application form via mail or email.
Be sure to include all supporting documentation

Canadian College of Professional
Counselling Practitioners
(CCPCP)
PO Box 23045
Vernon BC
V1T 9L8
Canada

For further information or inquiries:
Phone: **250-558-7700** or 1-866-704-4828
Email: inquiry@ccpcp.ca
Website: www.ccpcp.ca

Checklist for Advanced Practitioner Member Status

Each applicant for designation as an Advanced Counselling Practitioner will be evaluated by the CCPCP Examination Committee. The application process provides the opportunity for applicants to submit documentation to meet Prior Learning Assessment and Recognition (PLAR) criteria relating to the applicant's training, other credentials, membership, experience, and supervised practice counselling. (Additional fees for PLAR by the CCPCP may apply.)

Applicants to provide written documentation of the following:

- **Status as a Full Member in good standing with the CCPCP.**
- **Proof of liability insurance which includes coverage specific to the area of specialized practice.**
- **150 hours of advanced, competency-based training specific to the chosen area of specialization.** Training to be completed through accredited college or university courses that include skill practice; certified professional development programs; or a combination of both.
Applicant to provide transcripts and certification of program completion.
- **A total of 50 hours of consultation with a supervisor who has a minimum of 5 years clinical experience in the area of specialization.**
Documentation required:
--A referral letter verifying the supervisor's name, address and professional credentials; details of supervision to include number of hours, format of supervision sessions, and complete the Statement of Competence attesting to the counsellor's level of competence in area of specialization included with the application.
- **A minimum of 2 years of clinical practice working in the chosen area of specialization.**
Documentation required:
-- A referral letter from a colleague(s) verifying that the applicant worked in the area of specialization for a minimum of 2 years; complete and sign the **Statement Verifying Work Experience** included with the application
- **The ACP applicant designates one area of specialized practice from the following list.**
CCPCP is inclusive of ALL mental health practitioners who meet the competency standards for membership. If the applicant's specific area of specialization is not included below, the CCPCP Examination Board will evaluate a request for inclusion.

Youth and Family Counsellor
Play Therapy
Marriage Counselling
Sex and Intimacy Counsellor
Special Education Specialist
Grief Counselling
Addictions Counsellor
Spiritual Care Practitioner
Solution Focused Counselling
Vocational/Career Counselling
Geriatric Support Counselling
Clinical Supervision
Mediation
Behavioral Therapy
Mental Health Therapist

Dialectical Behavioral Therapy
Cognitive Behavioral Therapy
Equine Therapy
Executive Coaching
EMDR Therapy
Life Coaching
Hypnotherapy
Feminist-based Therapy
Music Therapy
Art Therapy
Internet Counselling
Trauma and Crisis Counselling
Group Counselling
Culturally-based Counselling

Applicant's Personal Information:

Name: First: _____ Last: _____

Type of Mental Health Practitioner:

Counsellor Therapist Coach Other _____

Area of Specialized Practice _____

Phone Number:

Home: _____

Business: _____

Address:

Home: _____

City: _____ Province: _____

Postal Code: _____

Business: _____

City: _____ Province: _____

Postal Code: _____

Training Programs Specific to your Area of Specialized Practice:

Institution	College/University Courses	Brief Description	Number of Hours	Date Completed

**Attach copies of certificates and/or transcripts verifying successful completion of specialized training.

Supervised Experience Related to Area of Specialization

**Minimum of 50 hours of direct supervision is required to be completed by the applicant.*

Title of Supervised Position: _____

Name of Business: _____

Address of Business: _____

City: _____

Province: _____

Postal Code: _____

Dates Employed:

From: _____ To: _____

Name of Supervisor:

First: _____ Last: _____

Previous positions related to Specialization:

Title of Position: _____

Name of Business: _____

Address of Business: _____

City: _____ Province: _____

Postal Code: _____

Dates Employed:

From _____ To: _____

Name of Supervisor: _____

Total Supervised Hours working in area of specialized practice

**A minimum of 50 hours of supervision required:*

**Please Attach a referral letter verifying the supervisor's name, address and professional credentials (supervisor must show 5 years of experience working in specialized practice).*

**Also include details of supervision to include number of hours, format of Supervision sessions, and Statement of Competence (see below) signifying Counsellor's level of competence in area of specialization.*

Statement of Competence:

***To be completed by most recent supervisor**

Based on the applicant's overall level of competence in the area of specialized practice, do you recommend / not recommend this applicant for professional designation as an **Advanced Counselling Practitioner** in the specified area of specialized practice?

Recommend: Not recommend:

COMMENTS: _____

On the scale of 1 to 10, where would you place the applicant's skill level? _____
(1 being the lowest, 10 being the highest)

Signature of Supervisor: _____ Date: _____

Witness Signature: _____ Date: _____

Supervisor Contact Information:

Supervisor Name and credentials:

First: _____ Last: _____

Length of time Supervisor has worked in this area of specialized practice? _____

Supervisor Business Address: _____

City: _____ Province: _____

Postal Code: _____

Email: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____

*Please list below the supervision dates and types of contact (ex. Individual, small group, phone, video)

50 hours of supervision in area of specialized practice-Attach Additional pages if needed.

Dates:	Contact:

Applicant's Current Work Experience related to Area of Specialization:

*Minimum of 2 years required

If you are currently working under supervision, please include the name of your supervisor:

Supervisor Name:

First: _____ Last: _____

Title of Current Position: _____

Name of Business: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Dates Employed:

From: _____ To: _____

Previous supervised positions related to Area of Specialization:

1.

Title of Position Held: _____

Name of Business: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Dates Employed:

From: _____ To: _____

If you were working under supervision, please include the name of your supervisor:

Supervisor Name:

First: _____ Last: _____

Supervisor's credentials:

2.

Title of Position Held: _____

Name of Business: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Dates Employed:

From: _____ To: _____

If you were working under supervision, please include the name of your supervisor:

Supervisor Name:

First: _____ Last: _____

Supervisor's credentials:

Total Length of Time Applicant was Employed in Area of Specialized Practice: _____ (a minimum of 2 years in specified field is required)

Please Attach- Referral Letter(s) from colleague(s) verifying that the applicant was employed in the area of specialized practice for a minimum of 2 years. Colleague to complete and sign the **Statement Verifying Work Experience included below. The referral letter must include colleague's name, contact information, and professional credentials.*

STATEMENT VERIFYING WORK EXPERIENCE:

**A minimum of 2 years work experience specific to the area of specialization*

**To be completed by a Professional Colleague of the Applicant who can attest to the Applicant’s experience as a mental health practitioner working in the specified area of specialization.*

Colleague’s Name:

First: _____ Last: _____

Title: _____

Credentials: _____

How do you know the applicant? _____

Business Address: _____

City: _____ Province: _____

Postal Code: _____

Telephone:

Work: _____ Home: _____

Cell: _____ Email: _____

Description of Applicant’s Work Experience: _____

I can verify the following Dates and Places of Employment listed by the applicant on this application.

Positions held by applicant that relate to Area of Specialization:

1.

Title of Position Held: _____

Name of Business: _____

Type of Business: _____

Dates Employed:

From: _____ To: _____

Colleague's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

2.

Title of Position Held: _____

Name of Business: _____

Type of Business: _____

Dates Employed:

From: _____ To: _____

Colleague's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Documentation Checklist:

Please attach additional pages as needed. Include the following documentation as detailed on the cover page of the application.

- ✓ **Documentation of full member status in the CCPCP.**
- ✓ **Copies of certificates and/or transcripts verifying successful completion of specialized training.**
- ✓ **Proof of liability insurance verifying coverage in area of specialization.**
- ✓ **Referral letter to include supervisor's name, address and professional credentials (supervisor must show 5 years of experience working in specialized practice); details of supervision-- number of hours, format of supervision sessions; and signed Statement of Competence.**
- ✓ **Details of Work Experience and signed statement from colleague.**
- ✓ **Make sure your application is signed, and all sections have been completed.**

Consent to Release Information

I understand that the information provided with this application will be used for evaluation purposes by the CCPCP Examination Committee.

I give permission to Canadian College of Professional Counselling Practitioners (CCPCP) to request information from my present and past employers, supervisors, colleagues, and any institution or agency with which I am, or have been, associated in a professional capacity.

I consent to the CCPCP consulting with any person who may have information on my competence and ethical standards of behaviour.

I hereby release from any liability, all representatives of CCPCP and all individuals and organizations who provide information to the CCPCP, while acting in good faith, to determine my credentials and character.

I am aware that any false or misleading information deliberately given is considered a serious matter and will result in denial of the application.

Yes, I have read and will adhere to the Professional Standards and Code of Ethics as outlined by the Canadian College of Professional Counselling Practitioners.

Please initial: _____

Applicant’s name (print) _____

Applicant Signature _____ **Date** _____

Witness Signature _____ **Date** _____

Payment of Fees

- Application fee for ACP status: **\$100**
- You will be billed the pro-rated amount of the membership dues after your application is approved. Membership fee to include Full Membership AND Advanced Counselling Practitioner status = **\$300 per year.**

This application must be accompanied by all attachments and the application fee.

Please make payment by credit card through the ‘Pay Now’ Link at www.ccpcp.ca

Or by cheque to:

CCPCP

P.O. Box 23045

Vernon, B.C. V0E 1B2

Please make checks payable to the CCPCP. Do not send cash. A receipt will be issued upon receipt of payment.