EXPERIENTIAL THERAPY CERTIFICATION

☐ **EXPERIENTIAL FACILITATOR LEVEL 1**

☐ **CERTIFIED EXPERIENTIAL THERAPIST (CET) LEVEL 2**

SECTION 1	**PERSONAL INFORMATION**

NAME *(as it appears on ID)*		
GENDER	MARITAL STATUS	NRIC OR PASSPORT NO.
HOME ADDRESS		
EMAIL ADDRESS:		TELEPHONE (MOBILE/HOME/WORK) / /
DATE OF BIRTH (*dd / mm / yy*) / /	PLACE OF BIRTH	CITIZENSHIP
OCCUPATION: EMPLOYER NAME & ADDRESS:		

SECTION 2	**ELIGIBILITY AND BACKGROUND INFORMATION**

EDUCATIONAL QUALIFICATIONS

QUALIFICATION	DISCIPLINE	INSTITUTION	YEAR
☐ Diploma ☐ Bachelor's degree ☐ Master's degree			

☐ Doctoral degree ☐ Other			

Please attach copies of certificate(s) with this application. Originals to be produced upon request

SECTION 3	**TRAINING IN PSYCHODRAMA, SOCIOMETRY, AND GROUP PSYCHOTHERAPY**
Number of Hours Obtained from Primary Trainer	
Number of Hours Obtained from all other TEPs	
Number of Hours Obtained from PAT (maximum 160 Hours)	
Hours Obtained from AGPA, ASGPP, or NADTA local, regional, and international meetings/conferences from presenters who are neither TEPs nor PATs (maximum 100 Hours Credit)	
Total Hours	

SECTION 4	**SUPERVISED EXPERIENCE**

Attach a description of your supervised experience. Describe each service (e.g., An on-going client, or an on-going group) or single session (a one time event). One paragraph is sufficient information for each service. For each service, please provide the following information:

- Date(s) of Service
- Type of Service (e.g., individual, couple, family, or group)
- Population Serviced
- Goals and Objectives for your work with this population, including expected outcomes
- Evaluation Measures employed to determine outcomes
- Specific psychodramatic, sociometric, and other experiential methodologies (i.e., assessments and interventions) used in your work with this population. Describe how these methodologies relate to the goals and objectives of the service

SUPERVISION SUMMARY	DATE THAT APPLICANT COMPLETED INITIAL 80 HOURS OF TRAINING (*MONTH/YEAR):*	
SUPERVISOR'S NAME & DEGREE	PSYCHODRAMA SESSION	SUPERVISION SESSIONS

TOTAL TRAINING HOURS ATTENDED:

DECLARATION & INDEMNITY

I hereby declare and affirm that all of the information given herein and on all attachments are true, correct and complete to the best of my knowledge. I am fully aware and hereby accept that my application will be rejected if any portion of this application or attachments is found to be false.

I hereby authorize APCB, its staff and agents to conduct verifications of my personal and professional information in connection with this application, and to have full and unrestricted access to the same information.

I agree to hold APCB, staff and examiners indemnified from any civil and/or criminal liability for damages or complaints about any action within the scope and arising out of the performance of their duties and which is taken in connection with this application, the examinations, grades received on examinations, and/or the decision of APCB not to issue me with a certificate.

APPLICANT'S FULL NAME:

APPLICANT'S SIGNATURE: _____ DATE: _____

PLEASE ENSURE THAT THE FOLLOWING DOCUMENTATION ARE ATTACHED:

- ☐ APPLICATION FORM (SECTION 1 – 4)
- ☐ SUPERVISOR'S FEEDBACK FORM
- ☐ TRANSCRIPTS & CERTIFICATES
- ☐ CODE OF ETHICS

FOR OFFICIAL USE ONLY

	DATE RECEIVED	RECEIVED BY	VERIFIED BY
DATE OF RECEIPT OF APPLICATION	/ /		
TRANSCRIPTS & CERTIFICATES	/ /		
CODE OF ETHICS SIGNED	/ /		
SUPERVISOR'S FEEDBACK FORM	/ /		
PROCESSING FEE	/ /		

APCB CERTIFICATE NUMBER ASSIGNED:

NAME ON CERTIFICATE: