# National Institute of Relationship Enhancement®

**Phone: 301-680-8977 Fax: 240-491-5956 Email: niremd@nire.org**

## APPLICATION FOR CERTIFICATION PROGRAM

Type of Training (Check one) _____ Supervision only _____ Certification Program _____ Certification as Approved Supervisor

Content Area (Check one)

_____ Child-Centered Play Therapy
_____ Filial Family Therapy
_____ Developmental Play
_____ Relationship Enhancement® Couples Therapy
_____ Relationship Enhancement® Family Therapy
_____ Relationship Enhancement® Program Leader

Dr. Mrs.
Ms. Mr. _____
(Circle) First Name Initial Last Name

Home Address _____

_____

Email: _____ Phone (_____)_____

1. _____
Highest Degree Date Institution Field of Study (Clin. Psych., Social Work, etc.)

2. Are you licensed, certified, or registered in your state to provide mental health services independently (i.e., private practice) without supervision?

   YES _____ If YES, complete only question #4 on the back of this form.

   NO _____ If NO, you must complete questions #1-4 on the back of this form.

3. Name of Credentialing Body _____
(e.g., MD Board of Examiners of Psychologists; PA Board of Examiners for Social Work)

4. List titles/dates of workshops or academic courses conducted by NIRE-Approved Instructors which you have attended, or other parallel trainings you have received that are comparable which we can assess. Also, list any previous certifications by IDEALS/NIRE which you have received.

   _____

   _____

5. Memberships in Professional Organizations (if any): _____

6. I require a supervisor who has the following special credentials: _____

7. If you would like a certain supervisor, please give name here: _____

**Please submit your completed application to niremd@nire.org**
**The application fee of $145 can be paid via the Donate Link at www.nire.org.**

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**For Office Use: Fee received ____/____/____ Approval: Yes ____ No ____ Assigned to _____on ____/____/____**

# Supervision Verification Form

(Items 1-3 to be completed **only** if applicant answered "NO" to Question #2 on front of application)

1. If you are currently a student in a graduate program in mental health, please provide the name of the university in which you are enrolled, the name of the department or program, and your program advisor's name and phone number below:

_____

_____

2. If you have completed a graduate degree in a mental health field but are required by your state's laws to be supervised in order to provide mental health services (i.e., you are not licensed or certified to practice independently), please provide the name of your place of employment (if applicable), and the name and phone number of your clinical supervisor below:

_____

_____

3. TO BE COMPLETED BY APPLICANT'S CLINICAL SUPERVISOR

The professional named on the reverse side of this form has applied to participate in a training and/or certification program offered by NIRE. The purpose of this form is to verify that the applicant is providing therapeutic services in accordance with applicable state laws while in training with NIRE, and in addition to ensure that the applicant's clinical supervisor is aware of the applicant's participation in our training program.

**I affirm that the applicant has informed me of his/her intent to participate in the training and/or certification program offered by NIRE. I affirm that throughout the applicant's training with NIRE, he/she will be providing mental health services and receiving supervision for such services in accordance with applicable state laws. I recognize that the assigned NIRE staff member will serve only as a consultant to the applicant, and that the ultimate responsibility for supervision of any therapeutic services and the making of clinical decisions resides with me.**

_____ _____

Signature Date

4. TO BE COMPLETED BY **ALL** APPLICANTS:

**I affirm that throughout my training with NIRE, I will be providing mental health services and receiving supervision for such services in accordance with applicable state laws. I recognize that the NIRE-approved supervisor assigned to me will serve as a consultant to me in the process of being trained and/or certified in specific therapeutic skills, but that the ultimate responsibility for clinical services provided and clinical decision making remains with myself (if licensed to provide therapeutic services independently of supervision) or with my clinical supervisor (if not licensed to provide therapeutic services independently).**

_____ _____

Signature Date

For questions about this form, please contact Rob Scuka, Ph.D. at (301) 680-8977. (8/23)