

**PROFESSIONAL’S REPORT**

**TO SUPPORT A THERAPIST’S APPLICATION FOR THE ACQUIREMENT OF THE LEVEL OF TRANSITIONAL ACCREDITATION AT THE HELLENIC INSTITUTE FOR RATIONAL-EMOTIVE & COGNITIVE BEHAVIORAL THERAPY**

The Hellenic Institute for Rational-Emotive & Cognitive Behavioral Therapy monitors and arranges accreditation criteria for those RECBT scientists/professionals who wish to proceed in the acquisition of a transitional accreditation level as RECBT therapists.

Applicant’s Name:

Acquisition Pursuit of Transitional Accreditation: Yes/No

To take into account the present application, we ask for the report of a professional who is familiar with the content and level of clinical practice of his/her candidate.

If you are willing to provide a report for the applicant, please fill in this form and return it to him/her in an envelope. We hope as part of the best practice that this Report has been discussed in detail with the candidate and any doubt issues existed, have been fully resolved. The Hellenic Institute for Rational-Emotive & Cognitive Behavioral Therapy, can contact you to discuss the contents of this report.

This form must be filled at the computer and then printed for a signature.

**PROFESSIONAL’S BACKGROUND**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name | |  | | | | | | | | |
| Address | |  | | | | | | | | |
| Post Code | |  | | | | | | | | |
| Tel. | |  | | | | | | | | |
| E-mail | |  | | | | | | | | |
| **Professional’s Credentials**  To fill the present report as an RECBT/CBT Professional for therapists who are applying for accreditation at the Hellenic Institute for Rational-Emotive & Cognitive Behavioral Therapy, the Professional must be a regular member and a fully accredited member of any recognized RECBT or CBT institution, so that he/she can complete with reliability and validity the present Report. Professionals must also currently implement RECBT/CBT.  Please provide with information about your RECBT/CBT skills, experience and your current practice. | | | | | | | | | |
| Regular Member of the Institution |  | | **Accredited RECBT/CBT Professional from the Institution** | |  | | **Accredited RECBT Supervisor from the Institution** | |  |
| *\** If you are a certified professional or a supervisor of the Albert Ellis Institute, the British Association for RECBT, or the British Association BABCP, you do not need to give any details to the next four fields. All other professionals or supervisors should provide information in these fields. | | | | | | | | | |
| Other RECBT/CBT Group/Organization/Association | | | | | |  | | | |
| Qualifications RECBT/CBT | | |  | | | | | | |
| Training in RECBT/CBT | | |  | | | | | | |
| Utilization experience of RECBT/CBT | | |  | | | | | | |
| **All Professionals should complete the following fields in this form.** | | | | | | | | | |
| Title Work/Professional Position of the Professional | | |  | | | | | | |
| Details of the Professional’s current RECBT/CBT work | | |  | | | | | | |
| **Relationship with the Applicant** | | | | | | | | | |
| Are you the current Supervisor of the applicant? | | | | Yes  No | | | | | |
| What is your professional relationship with the applicant? | | | |  | | | | | |
| How long do you acknowledge the RECBT/CBT activity of the applicant? | | | |  | | | | | |
| What is the frequency and the duration of supervision meetings? | | | | Individual:  Hours per month  Group/Peers: Hours per month  Number of persons inside the Group | | | |  | |

**DETAILS FOR THE APPLICANT’S CURRENT CLINICAL ACTIVITY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Profile of Clinical Practice** | | | |
| Type of Clients  *Adults / children / learning difficulties etc.* |  |
| Types of problems encountered |  |
| REBΤ/CBT therapeutic approaches |  |
| **Documentation’s Nature** | | | |
| What is the nature of documentation that you have for the clinical activity of your supervised therapist?  *Live assessment / case studies reports / letters / role playing / discussion / contribution to the groups of supervision etc.* |  |
| **Live Supervision:** It is aprerequisite for achieving Accreditation to include regular live samples of clinical practice of your supervised trainee, during supervision. These can be a live observation, a one-way mirror, video or audio file**.** | | | |
| In how many cases has the live professional communication been used during the last 12 months? |  |
| How many client’s cases have been covered in your knowledge? |  |
| How do you assess your supervised therapist adequacy?  *Supervisors are encouraged to use measures of adequacy like the CTS-R.* |  |

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| --- | --- |
| **Skills and Other Aspects of Development** | |
| To your knowledge, which specific skills and fields of adequacy, have become the object of elaboration during the last 12 months? |  |
| Within limits of confidentiality, please provide a representative example |  |
| What other aspects of RECBT skills development have become the object of elaboration and training? |  |
| **Level of Understanding of the Therapeutic Relationship. Level of Adequacy from the part of the Supervised Professional.** | |
| To your knowledge, what is the candidate’s level of understanding on the development, maintenance and termination of therapeutic relationships? |  |
| What kind of documentation do you have for the adequacy of the Candidate to manage the therapeutic alliance? |  |
| Within limits of confidentiality, please provide a representative example. |  |

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| **Total level of Adequacy in RECBT** | | | |
| What kind of documentation do you have for the ability of the supervised therapist to practice his/her clinical activity safely and effectively? |  |
| Do you have concerns about the current clinical activity of your supervised therapist? |  |
| What actions do you do to address these concerns? |  |
| Based on your contact with your supervised therapist, does it comply with the valid codes of ethics of RECBT/CBT; |  |
| Would you recommend the applicant for the acquirement of the level of Transitional Accreditation?  **IF NOT,** please provide details concerning changes which need to take place. |  |
| What additional comments would you do, in order to support the present application of the supervised therapist? |  |

**AFFIRMATION**

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| --- | --- | --- | --- |
| ***This report is an honest assessment/evaluation of the Applicant within the limits of my knowledge for him/her. Each element of doubt or concern referred in this Report has been thoroughly discussed with the Applicant.*** | | | |
| Professional’s Signature | Date |

**After completion, return this Report to the Applicant (preferably placed inside a sealed envelope).**