**

**ISST Application Form for Certification 2018**

**Check appropriate boxes for type and level**

Individual ST ☐ ☐StandardGroup ST☐ ☐Advanced

Couples ST ☐

Auxiliary ST☐

**Name (**as you want it on your certificate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Academic Credentials** (degree, discipline, year awarded**)**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Licensed as Psychotherapist: \_\_\_\_\_\_\_\_\_\_\_(yes) \_\_\_\_\_\_\_\_\_\_\_\_\_ (no)**

**Type of License and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of License (date of renewal / expiration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*For Auxiliary Professionals list license if applicable – e.g., Nurses*

*To qualify for Standard or Advanced level certification in Schema Therapy (other than Auxiliary Professional Certification – requirements below\*) a person must fulfill the following two qualifications:*

*1. Academic training: Hold at least a master's degree in psychology, clinical social work, psychiatric nursing or a counseling area that leads to licensing; or a medical degree with psychiatric residency (or residency equivalent if it is defined differently in that country).*

*2. License or certification for practice: In countries that certify or license the above professions, a person must be certified or licensed by either the government body or professional organization which grants this. If no such control exists in a country, the standard of one of the national or international professional psychotherapy organizations must be met to fulfill this requirement.*

*If you belong to another group that is licensed or certified to practice psychotherapy in your country, please submit this information with your academic qualifications to be considered for certification application. If your country has a specific qualification it must be met (e.g. UK)*

Please ask the Training & Certification Coordinator for a review by the Certification Committee which has members representing international areas if in doubt about whether you or a training applicant meets these qualifications and to have alternatives evaluated. [Coordinator’s email](mailto:farrell@iupui.edu)

**TRAINING COMPONENT**– list the modules **or the full program** you attended

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Workshop Name | Subject(s) covered\* | Hours \*\*\*  Specify: | Number of  participants | Trainers\*\* | Dates |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |
|  |  | Didactic: |  |  |  |
| Role-play: |  |  |

**In case of an application by individual studies you must describe the modules above and attach a certificate of completion for each seminar or module, signed by the trainer.**

**If you enrolled in a full training program, the signature of the training director is sufficient to document your participation.**

**Date you began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and date you completed the training component of certification: \_\_\_\_\_\_\_\_\_**

**Signature training director:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*\*Please be reminded that all trainers and supervisors must Trainer-Supervisor certification and be an active member of ISST (i.e. dues are current)*

*\*\*\* Please be aware: Only 6 hoursof the didactic part of the curriculum may consist of didactics/lectures for an audience of more than* ***40*** *participants.*

*\*\*\*\*For the dyadic/practice/role-plays part of the curriculum: The maximum is* ***20*** *participants if there is one trainer.*

**Total number of hours completed:** *ONLY LIST INDIVIDUAL ST CERTIFICATION COURSE WORK – not other conference or non-certification or for a different specialty certification (e.g. Couples)*

**Didactic Hours (minimum 25 hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supervised Role-playing / Dyadic Practice (minimum 15 Hours): \_\_\_\_\_\_\_\_\_\_\_\_\_**

Date you completed the training component of certification **:\_\_\_\_\_\_\_\_\_**

**SUPERVISION**

20 Hours of supervision required for Standard Certification

40 Hours of supervision required for Advanced Certification

***There is a maximum of 3-years to fulfill the supervision requirement and tape rating(s), once training* *is completed****. Exceptions for special circumstances, i.e., health, financial, family crises, etc., that require extensions on supervision time, will have to be authorized by the ISST Training Coordinator* ***in advance of your application****.*

**Total number of hours of supervision completed:\_\_\_\_\_\_\_\_\_\_\_\_**

**Date begun (Month/Year) \_\_\_\_\_ /\_\_\_\_\_ TO date completed: \_\_\_\_/\_\_\_\_\_\_\_**

**Name of Supervisor(s) and supervision hours (individual/group minutes):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* *Supervisors must be approved, advance level certified supervisor-trainers in the specialty area you are applying for and registered with ISST. They also must be current in payment of dues, completion of Continuing Education and evaluation requirements when they provided supervision or training for you. This should be checked by consulting the ISST website listing of supervisor-trainers* [*www.schematherapysociety.org*](http://www.schematherapysociety.org)
* *The supervisor is required to send a brief letter of confirmation by email of the supervision hours and the number of patients that were being treated during supervision, to the Certification Review Committee member for the region in which you practice.*

**TREATMENT HOURS AND NUMBER OF CASES**

**Total amount of treatment hours/diagnoses:**

***Standard certification*** *- at least 2 cases of minimum 25 sessions and 80 sessions in total. One patient with a personality disorder or significant personality disorder features and one patient who is appropriate for Schema Mode work due to complication, chronicity, failure to respond to treatment or relapse.) For specialty certifications consult the requirements listed.*

***Advanced certification*** *— at least 4* cases *of minimum 25 sessions and 160 sessions in total (One patient with a personality disorder or significant personality disorder features and the remainder patients who are appropriate for Schema Mode work due to complication, chronicity, failure to respond to treatment or relapse.) For specialty certifications consult the requirements listed.*

|  |  |  |
| --- | --- | --- |
| **Patients Initials** | **Number of sessions** | **Diagnosis (es)**  **Or modes** |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Name of rater(s)** | **Rating Score** | **Date of rating** | **Diagnoses/modes** |
|  |  |  |  |
|  |  |  |  |

**COMPETENCY RATING SCALE**

* *The rater(s) must be an independent supervisor (not the training supervisor), preferably one who does not know the applicant well, and must send confirmation of the score, along with the summary sheet from the STCRS form, by email to the regional representative. The tape must show a whole therapy session.*
* *For Advanced level certification* ***each tape must be rated by a different qualified rater.***
* *Standard Certification: 1 audio or video taped session must be rated, with a minimum STCRS score of 4.*
* *The patient must be one who is appropriate for Schema Mode work due to complication, chronicity, failure to respond to treatment or relapse.*
* *Advanced Certification: 2 audio or video taped sessions of 2 (different)  
  patients must be rated by two different raters with a minimum STCRS score of 4.5 for each one.*
* *One patient must have a personality disorder or significant personality disorder features and the second patient the same, or be appropriate for Schema Mode work due to complication, chronicity, failure to respond to treatment or relapse.*
* *Applicants at the Advanced level are expected to demonstrate competence with both the overcompensating modes and the avoidant/surrender modes.*
* *A case conceptualization form must accompany each session, along with the summary form for the session that the rater is going to listen to or view.*

I am an active Full (Supporting level for Auxiliary Professional Certification) member of the ISST since: \_\_\_ /\_\_\_ (month/year joined ISST).

I understand that I must be a full member of ISST and pay annual membership dues on time to maintain my status a an ISST certified schema therapist.

* Membership Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that all statements on the application are accurate and I agree to abide by the requirements and conditions of ISST certification at the level I am granted.

***Date:****……………………….* ***PRINTED NAME*** *……………………………………*

*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*