**Certified Child-Centered Play Therapist Supervisor**

**Certified Child-Centered Group Play Therapist Supervisor**

**Renewal Application**



**This renewal application is completed for both CCPT-S and CCGPT-S certification renewal.**

**I am renewing:**

 CCPT-S Certification

 CCGPT-S Certification

 CC

**Applicant Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as you want it shown on the certificate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (home/cell)

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I want to be listed as an active provider on the online directory of *Certified CCPT* providers and understand that my contact information listed above will be included in this directory.

I want to be listed as an active provider on the online directory of *Certified CCPT* supervisors and understand that my contact information listed above will be included in this directory.

**Employment Information**

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Setting: Private Practice Agency School University Hospital Other

Employer Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been employed at this business/agency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licensure/Credentials**

Mental Health License Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issuing State: \_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_

*Other current credentials held: (please spell out)*

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

**Continuing Education Requirements**

Please complete the table below with the required 12 continuing education hours specific to CCPT/CCGPT over 5 years.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Workshop Title** | **Workshop Presenter** | **Workshop Location** | **Workshop Date** | **Workshop CE hours** |
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**Certification Application Fee: $95**

* I paid my $95 certification application fee online.

**Acknowledgements**

Please initial next to each item to indicate agreement:

\_\_\_\_ I understand that my CCPT/CCGPT supervisor certification must be renewed every *five (5) years* on November 1 of the given year my CCPT/CCGPT supervisor certification expires.

\_\_\_\_ I understand that CPT reserves the right to audit my renewal application, including providing

 evidence of completion for the required 12 hours of CCPT/CCGPT continuing education.

\_\_\_\_ I will contact the Center for Play Therapy in writing to modify contact information or terminate my

 certification as a Certified CCPT/CCGPT Supervisor.

\_\_\_\_ I understand that my CCPT/CCGPT Supervisor certification is no longer valid if at any time my mental health

 license is suspended or inactive.

**CCPT Practice Agreement**

As a child-centered play therapist, I believe that children have an inherent tendency towards growth and are capable of positive self-direction. In practice, I will honor the child’s potential to move toward self-enhancing ways of being and encourage parents and caretakers to recognize the innate capacity of the child to seek wellness. Additionally, I will seek to establish a relationship with each child characterized by genuineness, unconditional positive regard, and empathic understanding. I will adhere to CCPT attitudes, principles, and procedures during the provision of child-centered play therapy services.

* I agree

By signing this document, I verify that information I provided in this application is accurate and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant’s Signature Date Center for Play Therapy agent Date**

Upon completion of this application, please submit to Stephanie Carr at **cpt@unt.edu**