**Certified Child-Parent Relationship Therapist Supervisor**

**Application**



**Applicant Information**

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

Name as you want it to appear 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 CPRT* 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 CPRT* 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Graduate Education**

Please list in chronological order starting with most current:

|  |  |  |
| --- | --- | --- |
| **Degree** | **Institution/University** | **Graduation Date** |
|  |  |  |
|  |  |  |

**Licensure/Credentials**

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

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

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

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

**CPRT Educational Requirements**

* I hold a Level 2 CPRT certification or meet the requirements to hold a Level 2 CPRT certification and **I have attached evidence of the CPRT certification**.

I completed all educational requirements and **I have attached evidence of completion for all requirements** (e.g., certificates of completion of CPRT 101 & 102 or equivalent, CPRT Supervision Workshop, transcript, course syllabus, workshop handouts/materials, etc.).

**CPRT Supervised Experience Requirements**

Name of your CPRT-Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Dates of CPRT Supervised Experience: \_\_\_\_\_\_\_\_\_\_\_ (start date) to \_\_\_\_\_\_\_\_\_\_\_ (end date)

I verify that I completed 3 CPRT groups under supervision *after* completing CPRT 102 or its equivalent (this is only if you are not already CPRT Level 2 Certified)

* I verify that I completed 2 additional CPRT groups under supervision with an approved CPRT supervisor with a minimum of 8 hours of supervision per group (two groups can be conducted simultaneously with a minimum of 12 hours of supervision).

I verify that I completed eight 1-hour supervisory sessions for a beginning CPRT practitioner, while participating in weekly supervision from an approved CPRT supervisor for a minimum of 5 supervision of supervision hours.

***Completed by supervisor:***

As a supervisor of the applicant’s CPRT practice, do you have any reservations about the applicant being certified for the independent practice of CPRT? Yes No If yes, please specify:

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

By signing below, I verify that I have supervised this applicant for a minimum of 8 hours of supervision as they conducted at least 2 CPRT groups.

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

**Approved Certified CPRT-Supervisor Signature Date**

**CPRT Supervision Supervised Experience Requirements**

Name of your CPRT-Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Dates of CPRT Supervised Experience: \_\_\_\_\_\_\_\_\_\_\_ (start date) to \_\_\_\_\_\_\_\_\_\_\_ (end date)

* I verify that I have completed 8 supervisory sessions for a beginning CPRT practitioner under weekly supervision from an approved CPRT supervisor for a minimum of 5 supervision of supervision hours.

***Completed by supervisor:***

As a supervisor of the applicant’s CPRT supervision practice, do you have any reservations about the applicant being certified for the independent practice of CPRT supervision? Yes No If yes, please specify:

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

By signing below, I verify that I have supervised this applicant for a minimum of 5 hours of supervision of supervision over 8 sessions of CPRT supervision.

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

**Approved Certified CPRT-Supervisor Signature Date**

**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 CPRT supervisor certification must be renewed every *five (5) years* on November 1 of the given year my CPRT supervisor certification expires.

\_\_\_\_ I will contact the Center for Play Therapy in writing to modify contact information or terminate my certification as a Certified CPRT supervisor.

\_\_\_\_ I understand that my CPRT supervisor certification is no longer valid if at any time my mental health license is suspended or inactive.

**CPRT Practice Agreement**

As a child-parent relationship therapist, I embrace child-centered play therapy philosophy and believe that children have an inherent tendency towards growth and mastery that is facilitated within a parent-child relationship characterized by empathic understanding and unconditional positive regard. In practice of CPRT, I will support and encourage parent’s potential to be therapeutic agents in their children’s lives grounded in the belief that parents are capable of learning CCPT attitudes and skills that foster attuned and responsive parenting. I understand the need for intentional balance between providing parents dynamic support, didactic content, skills training, and supervised experience of weekly play sessions. I will exercise clinical judgement while adhering to CPRT philosophy and protocol outlined in the CPRT text (Landreth & Bratton, 2006, 2020) and treatment manual (Bratton, Landreth, et al., 2006, 2020) in provision of child-parent relationship therapy.

* 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**](mailto:cpt@unt.edu)**.**