

EMDR Humanitarian Assistance Programs, Inc.

2911 Dixwell Avenue, Ste. 201 Hamden, CT 06518 Telephone (203) 288-4450 Fax (203) 288-4060

Sign and return this agreement to the EMDR HAP office by fax or mail. If you are not licensed, have your licensed clinical supervisor complete and sign the CLINICAL SUPERVISOR'S APPROVAL FORM as well.

PARTICIPANT AGREEMENT FORM

The undersigned participant acknowledges that (s)he has been advised and understands:

1. EMDR HAP Training is available to clinicians who work thirty (30) or more hours per week for public or private not-for-profit organizations in a clinical mental health capacity. You will be asked to submit your employer's name, organization name, address, city, state, phone number and email address, as well as their signature. If it is determined that you do not work the minimum required hours at a not-for-profit organization you will not be admitted to the training and the fee paid for the training will not be refunded.
2. The boundaries of clinical applications of EMDR for anything other than PTSD have not yet been confirmed by controlled research. The cautions presented in the Training are based primarily on anecdotal reports by trained clinicians.
3. It is not unusual for a target memory to be linked to other, unexpected, disturbing material or memories.
4. A prerequisite for receiving a Certificate of Attendance is the completion of the three practica at the seminar, where clinicians will give and receive EMDR under small group supervision. The practice experience is for educational purposes only and not for personal therapy.
5. Case material presented didactically or on video may be disturbing to those with unresolved personal issues. Further with reference to numbers 4 and 5:
 - Clinicians presently engaged in personal therapy must seek permission from their therapist before participating in the Training; and
 - Those who presently have a dissociative disorder should not participate without informing the EMDR trainer at the training, and preferably the EMDR HAP office before the Training dates; and
 - Those with limiting or special medical conditions (such as but not limited to pregnancy, heart condition, ocular difficulties, etc.) must consult their medical professionals prior to participating in this Training.
6. Since the processing of targeted incidents may continue after training, other dreams, memories, etc. may surface. In such cases, it is the responsibility of the participant to seek and obtain appropriate assistance. Providing such assistance is neither a part of nor an extension of the Training. Clinicians who wish to continue with personal EMDR work can request referral information from the EMDR HAP office.
7. These experiential workshops (Part 1 and Part 2) are for clinical and research purposes only and will not qualify the participant to train others in EMDR.
8. Audio and/or video recording of the Training or any portion thereof is not permitted.
9. A Certificate of Attendance will only be issued to those who attend the full Part I Training and participate in the practica on all three days. A Certificate of Completion will only be issued to those who complete the Part II Training and participate in all practica and complete all 10 hours of consultation.

If not licensed, I agree to practice EMDR only under the supervision of a licensed mental health clinician. I certify that the registration information that I have submitted online and on this form is accurate.

Location and date of seminar you plan to attend _____
Location Date

Accepted and Agreed: _____
Participant's Signature Date

Please print your name _____

Verification of employment with a nonprofit – must be completed by Agency Administrator or HR Manager

I confirm that the participant submitting this form works 30 hours or more per week for our organization and that our organization is a public or private not-for-profit organization in a clinical mental health capacity.

Name of Organization: _____

Address, City, State, Zip, Country: _____

Phone Number: _____

Name and Title of Person Providing Verification: _____

Email Address of Person Providing Verification: _____

Signature of Person Providing Verification: _____

Your registration will be confirmed by email when we have received:

1. **the completed online registration form**
2. **payment of the fee**
3. **the signed Participant Agreement Form and (if you are not licensed) the Supervisor's Approval form. Mail or fax to the address/phone number at the top of this page.**

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CLINICAL SUPERVISOR'S APPROVAL FOR EMDR TRAINING OF SUPERVISEE

Please Print Name of Supervisee: _____

The Basic EMDR Training Program is open to licensed practitioners and to those who are on a licensure track if they are completing master's level coursework, and are being supervised by a licensed clinician in a clinical internship.

EMDR HAP Training is available to clinicians who work thirty (30) or more hours per week for public or private not-for-profit organizations in a clinical mental health capacity.

1. The boundaries of clinical applications of EMDR for anything other than PTSD have not yet been confirmed by controlled research. The cautions presented in the training are based primarily on anecdotal reports by trained clinicians.
2. It is not unusual for a target memory to be linked to other unexpected, potentially disturbing material or memories.
3. A prerequisite for receiving a Certificate of Attendance is the completion of the three practica at the seminar, where clinicians will give and receive EMDR under small group supervision. The practice experience is for educational purposes only and not for personal therapy.
4. Case material presented didactically or on video may be disturbing to those with unresolved personal issues. Further with reference to numbers 3 and 4:
 - Clinicians presently engaged in personal therapy must seek permission from their therapist before participating in the training; and
 - Those who presently have a dissociative disorder should not participate without informing the EMDR trainer at the training, and preferably the EMDR HAP office before the training dates; and
 - Those with limiting or special medical conditions (such as but not limited to pregnancy, heart condition, ocular difficulties, etc.) must consult their medical professionals prior to participating in this training.
5. Since the processing of targeted incidents may continue after training, other dreams, memories, etc. may surface. In such cases, it is the responsibility of the participant to seek and obtain appropriate assistance. Providing such assistance is neither a part of nor an extension of the training. Clinicians who wish to continue with personal EMDR work can request referral information from the EMDR HAP office.
6. The experiential workshops Part 1 and Part 2 are for clinical and research purposes only and will not qualify the participant to train others in EMDR.
7. Audio /video taping is prohibited.
8. A Certificate of Attendance (Part 1) will be issued only to those who attend the full Part 1 training and participate in the practica. A Certificate of Completion will be issued only to those who complete the Part 2 training, participate in all the practica, and complete the ten hours of consultation.

By completing the information below with your professional contact information and providing your signature, you confirm that you have read the description of EMDR and the method of training employed by EMDR Humanitarian Assistance Programs, Inc., you affirm the decision of your supervisee to participate in the training described and to use the clinical knowledge acquired in the training, as appropriate, in the clinical work that you supervise, and you confirm that you supervise the supervisee at the organization listed on the Participant Agreement Form (s)he is submitting to EMDR HAP.

SUPERVISOR INFORMATION:

Please Print Name and Title: _____

Phone Number _____ Email address _____

Name of Organization: _____

Address, City, State, Zip, Country: _____

Your Academic Degrees: _____

Your License Number: _____

Licensing Authority/Jurisdiction: _____

Supervisor's Signature _____ Date _____