

## Supervisor Candidate Application Form

This form declares that the supervisor candidate is working towards the requirements for EFT Supervisor. This form is to be submitted to the International Centre for Excellence in EFT and will be signed by a representative and returned to the applicant. The purpose of the form is to inform ICEEFT of the candidate's plan for attaining supervisory status and to verify to potential supervisees that the candidate is actively training to be an EFT Supervisor.

**NOTE: THIS FORM NEEDS TO BE COMPLETED BEFORE ANY SUPERVISORY WORK CAN BE CONSIDERED FOR CERTIFICATION PURPOSES. YOU CANNOT INFORM SUPERVISEES THAT THEIR HOURS WILL COUNT TOWARDS CERTIFICATION UNTIL THIS FORM IS SUBMITTED AND ACKNOWLEDGED BY AN ICEEFT REPRESENTATIVE.**

Name of supervisor candidate: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

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

Professional Designation \_\_\_\_\_

Years of Couple/Family Practice: (minimum of 4 years)  
\_\_\_\_\_

Date of EFT certification: \_\_\_\_\_ (minimum one year following certification)

At the end of my training I will have:

- Completed a course on supervision for counseling/psychotherapy.
- Supervised a minimum of three trainee EFT therapists
- Submitted a written description of my experience in supervision: a) how many people I have supervised; b) number of cases I have supervised; c) a written description (approximately 1000 words) of how I believe my supervision fits with EFT principles of supervision and give specific examples to support my perspective
- I will have submitted two one-half hour tapes demonstrating supervision of two different therapists

**I understand that this application process and supervisor-in-training period needs to be completed within two years. I understand and accept the EFT model of supervision and plan to meet the requirements of this model with my supervisees.**

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Supervisor Candidate

Date

Signature: \_\_\_\_\_

1st Supervisor of Supervision Name:

Date

Signature \_\_\_\_\_

2nd Supervisor of Supervision Name:

Date

Signature \_\_\_\_\_

ICEEFT Representative

Date

Signature \_\_\_\_\_

Send completed form to:

ICEEFT

1869 Carling Ave Suite 201

Ottawa, ON K2A 1E6 Canada