**Application Form**

**CPCAB Level 4 Diploma in Therapeutic Counselling- BACP Approved Practitioner Qualification (TC-L4)**

Please note: All information is protected under the Data Protection Act 2018 and GPDR.

| **Location:**  Please state which location you would like to apply to: | | | | | | | | | | Sleaford (Lincolnshire)  Saturdays | | | | | | | | | | Kings Lynn  Wednesdays | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Payment type:** | | | | | Full payment | | | | | 10 Month Plan | | | | | | | | | | 12 Month Plan | | | | | | | | | |
| **Your details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mr/Mrs/Miss/Ms/  Other | | | |  | | | | First name: | | | | | |  | | | | | | | | | | | | | | | |
| Preferred pronouns: | | | |  | | | | Surname: | | | | | |  | | | | | | | | | | | | | | | |
| Preferred Name: | | | | | |  | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOB:  Entry requirements19+ | | | |  | | | | Email address: | | | | | | | | | | | | | | | | | | | | | |
| Telephone no: | | | | | | | | | | | | | | | | | | | | | |
| **Any health or allergies we need to be made aware of?** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Any medications we need to be made aware of, if something should happen while you are in our care?** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Next of Kin Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mr/Mrs/Miss/Ms/  Other | | | |  | | | | Surname: | | | | | |  | | | | | | | | | | | | | | | |
| Telephone no: | | | |  | | | | First name: | | | | | |  | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |

**Previous Qualifications**

| **Year (From and To)** | **Qualification and Subject** | **College/University & Awarding Body** | **Grade** |
| --- | --- | --- | --- |
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| **Please tell us a little about you and why you would like to do this course? (Max 500 words)** |
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|  |

| **Can you share your awareness of working with difference and diversity? (Max 300 words)** |
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| **Can you please write down any holidays you have that we need to be aware of.**  **(The course requires a minimum attendance)** | | | | |
| --- | --- | --- | --- | --- |
|  | | | | |
| **Please provide us with any additional learning requirements/medical conditions that you feel we need to be aware of so that we can support you in**  **being successful in this course.** | | | | |
|  | | | | |
| **Reference details:** | | | | |
| | Full Name: |  | | | | | --- | --- | --- | --- | --- | | Role: |  | | Email address: |  | | How long have you known them? | |  | | | | | | | |
| **Please be aware that this course involves experiential elements that will involve some personal disclosure and associated personal developmental activities.**  **This qualification is not suitable for those who are currently in a state of severe emotional difficulty**  **and/or severe psychological distress**  **Please confirm everything you have stated is true to the best of your knowledge.** | | | | |
| Name: |  | | | |
| Signature: |  | Date of signature: |  | |

When sending your application form, please provide a copy of, your Level 2 Counselling skills and Level 3 Counselling studies certificate, your identification, for example, Passport, driving licence etc, and proof of address. This can be sent to training@ckcounsellingandtrainingservices.co.uk

This is to ensure we have the correct details when applying for CPCAB registration and when your certificate is issued.

We aim to get back to you within 14 days of receiving your application form.