Declaration Form to be completed on behalf of the Health Service Provider by the Director of Nursing or Equivalent Authorised Manager and submitted with the application.

Programme Title: ____

Name of Applicant (as on NMBI or equivalent register): ____________________________________

Name of Health Care/Other Institution: ____

Applicant Practice Area: ____

To be completed by the Director of Nursing/Equivalent Authorised Manager

I wish to confirm the following:

1) The applicant will be working in the relevant specialist area for the duration of the programme for a minimum of 200 clinical hours over the two year period

2) The applicant will be released from practice to attend the programme requirements

3) The applicant will be allowed to attain a minimum of 40 hours of clinical supervision by a BABCP accredited CBT Therapist to support learning in the specialist area of practice for the duration of the programme

4) The applicant has completed a minimum of thirty six months full-time post qualification experience

5) The applicant will be supported in their attendance on the programme and clinical opportunities will be provided to enable the applicant to practice Cognitive Behavioural Therapy under supervision

Signed by the Director of Nursing/Equivalent Authorised Manager:

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Printed name of the Director of Nursing/Equivalent Authorised Manager:

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Date: __________________________