The Australian Association of Family Therapy Inc.
PO BOX 2351. RICHMOND VIC 3121. AUSTRALIA . Tel 03 9429 9938
www.aaft.asn.au admin@aaft.asn.au ABN 44 698 290 795

Advancing Family Therapy training and clinical practice since 1979.

Application for
Clinical Family Therapist Membership

(It is in your interests to read all the questions carefully, to understand what is asked of you and to complete accordingly.)

NB: Applicants must hold General or Professional Membership with AAFT in order to apply for Clinical Family Therapist Membership.

1. Applicant

Name _____

Address _____

Phone _____ Phone2 _____

Email (print clearly) _____

☐ Please tick ✓ if you wish to receive family therapy related information via email.
(eg. PACFA News, ANZJFT news, Professional Development info.)

2. Agency

Name _____

Address _____

Phone _____ Phone2 _____

Email (print clearly) _____

Position Held: _____

3. Your professional qualifications

* please provide **certified copies** of your qualifications

Name	Awarding Institution	Date Completed

(continued overleaf)

4. Family Therapy Training

*1. Please provide certified documentation (where possible)
*2. Please provide details of the numbers of hours of formal training programs, workshops and conferences. Please note that training must be specifically related to family therapy, not just the counselling area per se. If in doubt please include a written resume of the content of the courses and workshops you have attended.

Date	Name of training	Presenter/s - institution	Number of hours

5. Family Therapy Supervision

* See Point 4 in the Requirements for CFT Membership of AAFT Inc document.

5.1 Individual Supervision

Year/s	Name of supervisor/s	Total Hours (denote specifics i.e. face-to face or via remote access)

5.2 Group Supervision

Year/s	Name of supervisor/s	No.in group	Total Hours

6. Family Therapy Practice

* See clause 2 in the Requirements.
* Note: you must have clinical responsibility for these families.

Year/s	Agency	Position	No. of families	Number of contact hours

7. Name two referees

* They must be Clinical Family Therapist members of AAFT for 5 years, one being your Principal Supervisor and one being your Referee.

Name	Agency and address	Phone No	Professional relationship with you

8. Has any other professional organisation or registration board found you to have breached a code of ethics or to have engaged in unprofessional conduct?*
** A yes answer will not necessarily exclude membership, however further information may be sought.*

☐ YES ☐ NO

AAFT collects this information to protect the integrity of its membership. This information will not go beyond the Committee of Management and will remain on file for the duration of your AAFT membership.

9. Declaration

I declare that the above information is (to the best of my knowledge) true and correct.

In the event of my admission as a Clinical Family Therapist member of the Australian Association of Family Therapy. I agree to be bound by the rules of the Association for the time they are in force.

Signed _____

Date _____

Please return to:

AAFT Accreditation Sub-committee
PO BOX 2351 RICHMOND VIC 3121