



Advancing Family Therapy  
training and clinical practice  
since 1979.

## The Australian Association of Family Therapy Inc.

PO BOX 2351. RICHMOND VIC 3121. AUSTRALIA . Tel 0499 078 211

[www.aaft.asn.au](http://www.aaft.asn.au) [admin@aaft.asn.au](mailto:admin@aaft.asn.au) ABN 44 698 290 795

# 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