

Advanced Practitioner Certificate in Therapeutic Skills for Trauma Recovery

Surname:

First Name:

Address:

Phone Number:

Email:

Date of Birth:

PLEASE ANSWER YES OR NO and give details:

Are you a TISUK Practitioner?

Date completed and grade achieved

What is your job title? Please give a brief description of your role and responsibilities

Please give brief details of any previous training you have had regarding social, emotional, mental health and therapeutic skills (other than TISUK training)

What range of mental health issues are you currently supporting in children and young people?

Dates of personal psychotherapy or counselling with the therapists/counsellor's orientation if known (personal work is always seen as an asset for trauma informed work)

Please briefly state reason for wishing to attend this course and what you are hoping to gain as a result of the training

Please select the age range of your setting and the type of setting

Early Years Primary Secondary Post 16
Mainstream Specialist Provision PRU Other

Are you self funding?

Yes No

Is your employer funding your place?

Yes No

Invoicing details:

Name of school/organisation/individual

Address

Finance contact email

Tel no

Ethnic Origin

The Institute is committed to providing equal opportunities for all. To assist us with our confidential monitoring please choose one selection from A-E to indicate your ethnic group and tick the appropriate box to indicate your cultural background

A. White British Irish Any other White background (please specify below):

B. Mixed White and Black Caribbean White and Black African
Any other Mixed background (please specify below):

C. Asian or Asian British Indian Pakistani Bangladeshi
Any other Asian background (please specify below):

D. Black or Black British Caribbean African Any other Black background (please specify below):

E. Chinese or other ethnic group Chinese Any other (please specify below):

Country of Birth:

Country that you normally live in:

Nationality/dual nationality (as per your passport):

Disability / Additional Educational Needs (Please tick the appropriate box)

We encourage you to disclose any disability or medical condition which may affect your future studies. All offers are made on academic grounds and the information given here will be used to help provide services which meet your needs.

- | | |
|--------------------------------------------|--------------------------------|
| 0. No Disability | 5. Personal Care Support |
| 1. Dyslexia | 6. Mental Health Difficulties |
| 2. Blind / Partially Sighted | 7. Unseen Disability |
| 3. Deaf / Hearing Impairment | 8. Multiple Disabilities |
| 4. Wheelchair User / Mobility Difficulties | 9. Other Disability not listed |
| | 10. Autistic Spectrum |

If disabled, please provide brief details: