



Mindful – Centre for Training and Research
in Developmental Health
The University of Melbourne
50 Flemington Street
Flemington Vic 3031

T: (03) 9371 0220 F: (03) 9371 0250

CERTIFICATE IN CHILD, ADOLESCENT AND FAMILY THERAPIES

Original and one (1) copy should be sent to:

*Mindful – Centre for Training and Research in Developmental Health
The University of Melbourne
50 Flemington Street
Flemington Vic 3031*

by 30th November for Semester 1 intake, or 30th June for Semester 2 intake.
Late applications may be considered according to availability of places.

INSTRUCTIONS FOR COMPLETION OF APPLICATION FORM

Ensure that you have provided an address and telephone number where you can be contacted during the application process if this is different to your permanent address.

Please ensure that you have included the original plus one copy of:

- application form
- certified copies of academic transcripts. To obtain a certified document take the original and a photocopy and have the original sighted and photocopy signed by a general practitioner, pharmacist, dentist, school principal, etc.
- certified copy of proof of Australian citizenship or residency status
- copy of Developmental Psychiatry Course certificate, if applicable
- curriculum vitae
- nominated referees

**APPLICATIONS WILL NOT BE PROCESSED UNLESS
ALL DOCUMENTATION IS PROVIDED**

PLEASE DETACH AND RETAIN THIS COVER SHEET FOR YOUR RECORDS

CERTIFICATE IN CHILD, ADOLESCENT AND FAMILY THERAPIES

APPLICATION FOR ADMISSION

- Mindful Certificate in CAFT: Theory
- Mindful Certificate in CAFT: Theory and Clinical Practice

_____ (year)

SEMESTER ONE SEMESTER TWO
(please tick one)

1. Personal Details

Surname: (Dr/Mr/Mrs/Ms/Miss).....

Given Names:.....

Student Number: (If previously enrolled at this University)

Permanent Address:

.....

..... Postcode:

Telephone: (Home/Mobile).....(Business).....

Fax Number:..... E-mail Address:.....

Date of Birth:..... /..... /.....

2. Residential Status

- Australian citizen. (Please provide certified copy of birth certificate, passport or proof of citizenship).
- New Zealand citizen. (Please provide certified copy of passport showing residency visa or certificate of Australian citizenship).

- Holder of a visa giving permanent residence in Australia. (Please provide certified copy of passport showing permanent residency visa).

3. Academic Qualifications

This application must be accompanied by certified copies of **transcripts** of the qualifications listed. Applications will not be processed unless this documentation is provided.

Undergraduate Program:

University Attended	From	To	Qualification

Graduate Program: (If applicable)

University Attended	From	To	Qualification

4. Employment History

a) Attach a ***curriculum vitae*** detailing any other tertiary qualifications and relevant employment/experience, including dates.

b) Clinical Contact

In your work, how often do you meet with children? (Please circle one)

Never *Rarely* *Occasionally* *Regularly* *Always*

In your work, how often do you meet with adolescents? (Please circle one)

Never *Rarely* *Occasionally* *Regularly* *Always*

In your work, how often do you meet with parents? (Please circle one)

Never *Rarely* *Occasionally* *Regularly* *Always*

In your work, how often do you meet with families? (Please circle one)

Never *Rarely* *Occasionally* *Regularly* *Always*

c) Are you in a role where you are able to deliver therapy to children, adolescents and families? Yes/No

Please provide further details:
.....
.....

d) Current Employment

Profession:

Name of Current Position:.....

Place of Employment:

Work Address:

..... Postcode:.....

Telephone: (Work) Fax:

Email:

Please briefly describe the nature of the work you do:.....

.....
.....
.....

5. Referees

Please provide the names, addresses and telephone numbers of two professional referees who are knowledgeable about your recent work performance. New graduates may provide personal or professional referees.

REFEREE NUMBER ONE:

NAME:

ADDRESS:

..... Postcode:

PHONE:..... (Business Hours)

FAX: E-mail Address:

POSITION:

REFEREE NUMBER TWO:

NAME:

ADDRESS:

..... Postcode:

PHONE:..... (Business Hours)

FAX: E-mail Address:

POSITION:

6. Course Discovery

Please indicate how you learned about the Certificate in Child, Adolescent and Family Therapies.

- Direct Mail
- Professional Journal

Please specify:

- Internet
- Word of Mouth

Please specify:

- Email
- Other

Please specify:

7. Declaration

- I declare that the information provided by me is true and complete in every particular.
- I acknowledge that *Mindful* – Centre for Training and Research in Developmental Health reserves the right to reverse or vary any decision regarding admission made on the basis of incomplete or false information.
- I understand that I may be required to supply originals of all documents used to support this application
- I understand that I may be required to supply evidence that I meet English language proficiency requirements.
- I declare that I will be able to abide by Mindful’s policy on admission, fees payment and fee refunds.
- I understand that Mindful reserves the right to inform other tertiary institutions if any of the material presented with this application is found to be false.

Applicant’s signature: _____

Date: _____