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International Association of Eating Disorders Professionals
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APPENDIX D1: Application Form for Approved Supervisor

NAME:
____

ADDRESS:
____

CITY: ________________________________ **STATE:** ________ **ZIP CODE:** _______

TELEPHONE: (____) ___________________________ **FAX: (____)**
____

E MAIL ADDRESS:
____

QUALIFICATIONS (Please check all that apply):

I believe that I am qualified for designation of CEDA, CEDS, CEDAN, CEDSN supervisor by virtue of the following:

❒ I am a health care professional with a minimum of 5 years of behavioral healthcare experience and hold the appropriate state licensure, certification, or equivalent qualifications.

❒ I have had no fewer than 6,000 hours of approved work experience in the diagnosis and treatment of eating disorders.

r I am a current member of the International Association of Eating Disorders Professionals / Year of member inception: ____________.

❒ I have attended an IAEDP Symposium(s). Year(s) of attendance: ______________.

PLEASE EXPLAIN THE 6,000 HRS+ OF EATING DISORDERS EXPERIENCE (Please include names and addresses of supervisors, years at location, etc.)

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PLEASE LIST ALL WORK EXPERIENCE DURING THE LAST TEN YEARS:

PLEASE LIST YOUR ACADEMIC TRAINING:

PLEASE LIST ALL LICENSES AND/OR CERTIFICATION HELD:

PLEASE EXPLAIN THE AREA OF YOUR EXPERTISE (eg. Individual, group, family, etc.):

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PLEASE EXPLAIN YOUR THEORETICAL ORIENTATION (Cognitive behavioral, Psychodynamic, Family systems, etc.):

Has there ever been any ethical, legal, or professional, ethical hearing, malpractice, etc. brought against you? (must check one): ? Yes ? No

If yes, please explain (use additional pages if necessary):

**** PLEASE NOTE: NUTRITIONISTS MAY ONLY SUPERVISE NUTRITIONISTS, UNLESS APPLICANT HOLDS A MASTER'S DEGREE OR HIGHER IN COUNSELING (OR RELATED**

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FIELD, MSW, MS, PH.D., ETC.)

DOCUMENTATION:

- ❐ Yes. I have enclosed copies of my transcripts (unless they are already on file at the IAEDP office.
- ❐ Yes. I have enclosed a current copy of my C/V.
- ❐ Yes. I have enclosed copies of my recent licenses.
- ❐ Yes. I have enclosed a copy of my current malpractice insurance policy .
- ❐ Yes. I have enclosed two letters of reference from professional colleagues.
- ❐ Yes. I have enclosed one letter of reference verifying 5 years of cinical experience.

SIGNATURE:

I do attest that the information provided on this application is true and correct to the best of my knowledge. I will abide by the requirements of IAEDP as related to applicant certification and generally accepted principles of supervision, professionalism, ethics, and practice standards.

SIGNATURE:

I have checked with my local licensing board and/or malpractice insurance carrier and I may provide consultations and supervision to IAEDP members.

PLEASE TYPE or Print Neatly