



# Application

## Certification Program in Schema Therapy

### Schema Therapy Training Canada

**All applications and supporting materials for the 2025 program must be received by January 31, 2025.**

**Late applications will be considered if there are openings available.**

You may add additional pages to this application to clarify or elaborate on any of the questions below, if you need more space.

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Current Institution/Organization and Title (if any):

\_\_\_\_\_  
\_\_\_\_\_

**Work Address:** \_\_\_\_\_

City/Prov/Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

**Home Address:** \_\_\_\_\_

City/Prov/Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

\*Work Telephone: \_\_\_\_\_

\*Home Telephone: \_\_\_\_\_

\*Mobile Phone: \_\_\_\_\_ \*Fax: \_\_\_\_\_

Primary E-Mail (required): \_\_\_\_\_

Alternate E-Mail address (optional): \_\_\_\_\_

Website (optional): \_\_\_\_\_

I expect to complete the training program in:

- 1 year
- 2 years
- Don't Know Yet

Education & Work Experience

Highest Degree: \_\_\_\_\_ Year Earned: \_\_\_\_\_ Field: \_\_\_\_\_

If you are applying from outside of Canada, please explain the degree(s) you have obtained, and the exact field of study. (Please explain how many years of study are involved, and whether your degree is closest to a Bachelor's, Master's, or Doctorate degree in Canada.)

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University (include city and country): \_\_\_\_\_

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Describe your Internship, Practicum Work, or Residency (including name and location of Institutions):

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Describe any Postdoctoral Training:

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Licensure/Certification (if required in your country): \_\_\_\_\_

Province/Country: \_\_\_\_\_

**Essential:** List previous workshops and training in Schema Therapy, if any (include approximate dates, locations, hours, and instructors; add additional page if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the approximate hours per week you currently engage in the following professional activities:

\_\_\_\_\_ Direct patient contact      \_\_\_\_\_ Supervise Other Therapists  
\_\_\_\_\_ Administration      \_\_\_\_\_ Take courses; study  
\_\_\_\_\_ Research      \_\_\_\_\_ Other activities (please specify): \_\_\_\_\_  
\_\_\_\_\_

Main work setting/organization: \_\_\_\_\_

Current Position/Title: \_\_\_\_\_

I **currently** work with:

(Rate each category on a scale from 0-3 as follows: 0 =not at all, 1=occasionally, 2 =frequently, 3= almost always)

\_\_\_\_\_ Inpatients      \_\_\_\_\_ Children      \_\_\_\_\_ Individuals  
\_\_\_\_\_ Outpatients      \_\_\_\_\_ Adolescents      \_\_\_\_\_ Couples  
\_\_\_\_\_ Partial Hospital Patients      \_\_\_\_\_ Adults      \_\_\_\_\_ Families

\_\_\_\_ Criminal offenders

\_\_\_\_ Geriatrics

\_\_\_\_ Groups

\_\_\_\_ Other (please specify): \_\_\_\_\_

You may add additional pages if necessary to answer the following questions:

1. Please elaborate on your current professional work, including training, research, administrative and clinical activities.
2. Please elaborate on the nature and amount of clinical training **in schema therapy** you have already received.
3. Please describe your current psychotherapy orientation in detail, including the types of patients you work with.



7. **To be a candidate for the training program, you must be sufficiently fluent in English to participate in the workshops, to understand master therapy sessions on DVD's conducted in English, and to read schema therapy materials in English.**

**If you plan on obtaining certification, you also need to be sufficiently fluent to have individual case supervision sessions in English, and to submit patient session recordings conducted in English.**

Please answer the following:

A. I can submit audio or video recordings of actual patient sessions conducted in English:

1. YES \_\_\_\_\_ 2. NO \_\_\_\_\_ 3. UNCERTAIN \_\_\_\_\_

If you answered NO or UNCERTAIN to question A above, please answer the following questions:

B. I can submit verbatim transcripts of actual patient sessions, translated into proper English:

1. YES \_\_\_\_\_ 2. NO \_\_\_\_\_ 3. UNCERTAIN \_\_\_\_\_

C. I can submit audio or video recordings of actual patient sessions in the following language(s) other than English:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

8. Which level of certification are you applying for?

- \_\_\_\_\_ A. Advanced Certification
- \_\_\_\_\_ B. Standard Certification

9. If you are not applying for certification, please explain whether you plan to obtain additional training in schema therapy or certification in the future.
10. Is there any additional information about you that would be helpful to us in evaluating your application?
11. **Required:** On the following page, list two professional references who have supervised or observed your clinical work with patients. (The clinical work does not have to involve schema therapy, but ST is preferred.) Please ask them to forward a letter of reference directly to us at: [fmler.schemacda@gmail.com](mailto:fmler.schemacda@gmail.com)
12. **Optional:** Attach the name(s) of one or more other references who can discuss non-clinical aspects of your accomplishments (including work with schema therapy if applicable), such as research, teaching, or administration. Please ask them to forward a letter of reference directly to our Training Centre at: [fmler.schemacda@gmail.com](mailto:fmler.schemacda@gmail.com)

**1st Clinical Reference:**

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**2nd Clinical Reference:**

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please Read and Check the Boxes Below:

I understand that the standards set forth in this program may be slightly higher than those required by the Guidelines of The International Society of Schema Therapy (ISST). Required: Please put an X in the boxes below and add your name and date on the line indicated. If you will be using fax or postal mail, please sign on the line. If you will be applying by email, please type your name and date, or use an

electronic signature.  I understand that space is limited, and the workshop is only financially feasible for the Center(s) to offer based on the guarantee of a required minimal number of accepted candidates. Therefore, I understand, once my application is accepted and monies have been paid, there will be no reimbursements or refunds under any circumstances. I may have the option, space permitting, and at the sole discretion of the Directors, to apply unused monies I have paid to a future program or toward supervision—within the **next 12-month** calendar year.

I understand if I am unable to attend the "full program" in 2025 I may be able to makeup



“missed time” at another STTC Certification Program, providing there is a program offered and space available in the program. I am also aware that if space is not available, or the program is not being offered in a future calendar year, there may be the risk that I will need to pay to attend another ISST-approved program to fulfill the obligations of the curriculum requirements (that I missed) to achieve certification.

I understand that the ISST Guidelines hold forth that I must complete my certification no more than 3 years from the last day of the training program in the Spring of 2024.

**By placing an X in the boxes above—and by typing or signing my name and the date on the lines below—I am accepting these terms as legally binding.**

\_\_\_\_\_

Type or Sign Your Name

\_\_\_\_\_

Today’s Date

Please send us your completed application by email (as a Word attachment). Our contact information is:

**Schema Therapy Training Canada**

E-mail: [fmiller.schemacda@gmail.com](mailto:fmiller.schemacda@gmail.com)