# Biofeedback Certification International Alliance

## Mentor Application

*BCIA requires a new mentor application for the first prospective candidate and strongly encourages each candidate to file their certification application. Approved applications are valid for 1 year. Simply email the office to add names of new candidates you will be mentoring.*

**Name(s) of Candidate(s) for certification**: _____

_____

**Information below is to be about the Board Certified person to provide the mentoring.*

**Name of Certificant**: _____ BCIA#: _____

Address: _____

_____

Phone: (___) _____ E-mail: _____

**License/Credential for Independent Practice**

Mentoring is NOT supervision and is intended only to teach the application of skills.

A. Are you currently licensed/credentialed in your state to practice independently? ___ Yes

License #_____ Discipline_____ Exp Date_____

_____ No As an unlicensed provider**,** I agree to work under appropriate supervision when treating a medical or psychological disorder. _____ initial

B. Have you ever been reviewed or disciplined by a disciplinary or regulatory (licensing) agency?
_____ No _____ Yes If yes, please explain the circumstances and outcome.

C. Is your license/credential currently under review by a disciplinary or regulatory agency?
_____ No _____ Yes If yes, please explain the circumstances.

D. Have you voluntarily surrendered a license/credential?
_____ No _____ Yes If yes, please explain the circumstances and outcome.

**Biofeedback/Neurofeedback Experience,** totaling at least two years.

**Employment:** _____

Address: _____

Dates of Employment: _____

Description of Population Served: _____

_____

_____

_____

**Employment:** _____

Address: _____

Dates of Employment: _____

Description of Population Served: _____

_____

_____

**Employment:** _____

Address: _____

Dates of Employment: _____

Description of Population Served: _____

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## Agreement

1. I, the undersigned, do hereby make voluntary application to the Biofeedback Certification International Alliance (BCIA). I certify that the information given by way of this application is true, honest, and completely represents me. I understand that I must immediately inform BCIA if this information changes (e.g., loss of license or supervision).
2. I will conform to all applicable local, state, and federal regulations and conduct myself consistent with the highest standards relating to my profession and specialty. I understand that my certification will be invalid if:
   (a) my license is suspended, revoked, or not renewed due to an investigation of a complaint; and I am not allowed to provide services under supervision; or
   (b) I lose and cannot replace primary supervision for the treatment of a medical or psychological disorder. I may only apply for recertification after documenting a state-issued license in a BCIA-approved health care field or appropriate supervision.
3. I have read and agree to be bound by the BCIA Professional Standards and Ethical Principles of Biofeedback (PSEP) and their policies and procedures. I understand that the PSEP and any BCIA policies and procedures may be periodically amended and that I am bound by these documents as amended. I also understand that in accordance with such policies and procedures:
   (a) the final determination of any dispute arising between me and BCIA will be made by its board of directors and that I will be bound by the board's determination and may not seek review;
   (b) however, if grounds exist that would permit a court to overturn or modify the board's determination or otherwise act in the matter, that I will seek redress only in Denver, CO and only by arbitration in accordance with such policies and procedures; and
   (c) because I have agreed that the board's determination is final and binding upon me, I am likely to be required to pay the costs reasonable attorney fees, and other expenses of BCIA in any proceedings instituted by me.
4. I understand and agree that BCIA and its affiliates assume no responsibility for my actions or activities. I practice at my own risk and hereby release BCIA from any and all liability from any practice decisions I make.
5. I hereby give permission to BCIA to contact individuals or agencies listed for verification of information submitted and to provide information regarding my application and supporting documentation, upon written request, to state or national regulatory agencies (licensing/credentialing). I recognize that BCIA cannot accept my application if I refuse to grant permission for verification of my credentials and sharing my application and supporting documentation.
6. I attest that any education listed in application materials is from regionally-accredited academic institutions and that any suffix used to represent my credentials will be from BCIA-recognized health care fields.

Signature:_____Date:_____

**BCIA**

**5310 Ward Rd, #201 - Arvada CO 80002 - info@bcia.org – NO FAX**