



## ATTACH REGISTRATION APPLICATION For Occupational Therapists

### Contact Information:

Primary Contact's Name	_____
Agency/Practice Name	_____
Address	_____
City, State, Zip	_____
Work phone	_____ Fax _____
Email	_____ Website _____

### Applying for:

- Registered individual clinical membership
- Registered agency clinical membership
- Registered employee of a registered agency  
(Must be directly employed by agency)

### Services offered:

- Office based therapy
- Home based therapy
- Intensive home based therapy
- Therapeutic foster care
- Group care
- Residential treatment
- Other \_\_\_\_\_

### Typical Diagnoses for clients: (list)

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### Name of consultant(s) used for difficult cases (provision of consultant's CV required):

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### Consultant Contact Information

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**Attachments Required:** Scan in this checklist along with the Registration documentation.

Treatment Protocol (You may view the protocols of other Registered Clinicians at [www.attach.org](http://www.attach.org) under the Resources tab)

ATTACH Treatment Techniques Checklist

Informed Treatment Consent form, including a statement about the risks and benefits of therapy.

Copy of license (for each qualified practitioner)

Proof of professional insurance (agency-wide or for each qualified practitioner)

ATTACH Registration agreements (for each qualified practitioner)

ATTACH Disciplinary Disclosure statement (for each qualified practitioner)

ATTACH Malpractice questionnaire (for each qualified practitioner)

Qualifications chart (for each qualified practitioner)

- Please also scan CE certificates for each training unit listed

Resume/CV of applicant (for each qualified practitioner) listing all educational degrees

Resume/CV of Supervisor/Consultant (Does not apply if consultant has Registered Status with ATTACH.)

Fee for application as determined by the ATTACH Board of Directors

Registered Clinical Agency: \$400 + \$25 one-time, new applicant fee

Registered Clinician: \$175 + \$25 one-time, new applicant fee

Registered Employee of a Registered Clinical Agency: \$80 + \$25 fee

Additional fee if non-electronic submission: \$50

*\* A qualified practitioner is a clinician who meets the education and training requirements for ATTACH Registered status. Agency must have at least one practitioner who meets requirements.*

## Payment

Payment can be made online through the membership page on our website or sent by check along with your application or you can provide your credit card information below.

Total Due with Application _____
<input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Amex <input type="checkbox"/> Discover
Name on Card _____
Address of Card _____
Card # _____ Exp. Date _____

**E-Mail applications and supporting documentation electronically to:  
[questions@attach.org](mailto:questions@attach.org)**

## Instructions

In 2001 ATTACH initiated a registration process for clinicians and agencies. In 2017 this registration process was opened for Occupational Therapists as well.

The purpose of the registry is to:

- Provide more credibility to the term “attachment focused occupational therapist”
- Provide more credibility to your knowledge and attachment training (see information regarding required training hours below)
- Give parents and other professionals, access to names of potential treatment agencies and clinicians
- Allow parents and other professionals to contact you directly
- Supply you with a support and communication network to exchange information and/or ideas

ATTACH believes that occupational therapy in general, and specialized attachment-focused therapy, in particular, requires a combination of a degree that allows the clinician to practice in the jurisdiction in which they provide services, provides training in theories of human development and treatment approaches, coupled with supervised practice under the direction of an experienced and skilled clinician.

To obtain registered status with ATTACH a clinician, or the lead clinician in a clinic, must:

- Be able to prove current clinical licensure (or equivalent in foreign countries; or sanction by a governmental entity that the person or clinic is legally able to practice within the jurisdiction)
- A minimum of 40 hours of clinical training in attachment, trauma, or related fields beyond the degree
- Have a minimum of 40 hours of clinical training in Sensory Integration / Processing within the past 5 years.
- Have 2 years (minimum of 24 hours) of supervision by clinician skilled in attachment-focused treatment – attachment . sensory integration
- Possession of professional liability insurance
- An applicant must also agree, in writing, to abide by ATTACH's policy and procedures as outlined in the *White Paper on Coercive Treatment, Attachment-Focused Therapy: A Professional Practice Guide* and other relevant ATTACH policies and documents.

## Option for long term practicing Occupational Therapists

Over the years many occupational therapists have been involved in attachment and trauma informed care in their own vocational domains, though never officially registered with an organization such as ATTACH. For such practitioners there is an opportunity to waive the 24 hour supervision rule stated above. Please use this space below to explain your situation, affiliations, and reasons for being included in this registry:

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If you are willing to be a mentor / consultant for aspiring occupational therapists to complete their 24 hour agreement as well as ongoing supervision in difficult cases, please state your motivation in this space below:

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As of January 2017 only registered members of ATTACH have been given as resources to inquiries for clinical services. In an effort to assist families and workers to make informed decisions, ATTACH will print your registration information on our website; and mail out this same information to those who make inquiries. If you wish to be part of ATTACH's resource listing of Registered clinicians and agencies, please submit the attachments outlined above. *Requirements are subject to change. Please check the website prior to and during the application process.*

Clinicians in private practice must submit the complete packet of information. Registering agencies must submit the complete packet of information about the lead clinician and all qualified staff (if applicable) who will be working with attachment clients. Those applying will be considered to have regular clinical status until the application has been approved.

Upon receipt of a complete application, your documents will be forwarded to the registration review Committee. Should the committee have any questions concerning your application the chair of the committee will contact you directly or through the ATTACH office. ALL RESPONSES to questions should be sent directly to the ATTACH office at [questions@attach.org](mailto:questions@attach.org). Your response will be included in your file and forwarded to the Committee for review. Once approved,

you will receive a certificate in the mail, your information will be placed on the ATTACH website under the Resources section, and the Registration Review Committee will destroy their copies of your registration application. The original application will be kept on file at the ATTACH office.

Qualifications and required documentation for registered status with ATTACH are subject to change without notice. All applications should be submitted electronically in their entirety. A service charge of \$50 will be assessed for applications sent by fax or mail.

### **Treatment Protocol**

✓ Your Protocol will be put onto our website so we expect you to provide specific, complete, succinct descriptions that are family friendly.

**Philosophy:** In your own words, briefly describe your basic treatment principles and treatment approach regarding your attachment practice.

#### **Description of processes:**

***Intake/ Admission:*** Describe your intake and initial assessment procedures including specific tools/ instruments used. Include when and how you would refer a client elsewhere.

***Assessment:*** Describe how you assess your client's functioning and needs. Include what and how you gather historical information including:

- Social history
- Psychological history
- Treatment history
- Education history
- Medical history
- Developmental history
- Attachment history
- Family functioning
- Diagnoses
- Intellectual & cognitive skills & deficits

***Treatment planning:*** Briefly describe your treatment planning process; include a description of contracting when used; describe the client's role in planning.

***Treatment techniques used:*** Use the *attached checklist* and explain as necessary.

***Safety/risk management plan:*** Describe how you ensure the physical and psychological safety of your clients and yourself during treatment. Be detailed and specific to your practice and setting. See safety principles in ATTACH's *Professional Practice Manual* for guidance.

***Evaluation /outcomes/ follow-up:*** Explain how you evaluate the progress of your clients; and how you track outcomes of your practice. If you have follow-up procedures, please describe; if you don't, describe why.

## ATTACH Registration Process

**Treatment techniques used:** Use the *attached checklist* and explain as necessary.

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# **ATTACH Registration Process**

## **Renewal**

A registered member must submit necessary changes, corrections, additions, deletions to their protocol annually along with a copy of their license and malpractice insurance and a signed attestation form to maintain registered status. 10 annual trauma and attachment focused CEUs are required for each registered clinician and each clinician in a registered agency, with proof of 30 credits being required during the 3-Year Review process. ***A full registration packet must be submitted electronically every three years to maintain registered status.***

## **Complaints & Appeals**

Applicants who wish to appeal the Registration Review Committee's decision may appeal to the Executive Committee of the ATTACH Board of Directors. The appeal must be in writing and explain the basis for the appeal and the reason the applicant believes that an incorrect decision and conclusion was reached. All appeals must be received in writing at the ATTACH office within 60 (sixty) days of the date of notification to the applicant of the Committee's decision.

The Executive Committee will review all materials used by the Registration Review Committee as well as all materials submitted by the applicant in support of the appeal, and will render a decision within ninety days after all materials have been received and all relevant questions have been responded to by those involved.

**ATTACH Registration Agreement**  
**(To be completed by each qualified therapist in an applicant agency)**

Please check your understanding of and agreement to the following statements:

I have read ATTACH's publications *White Paper on Coercion in Treatment* and *Attachment-Focused Therapy: A Professional Practice Guide*, and understand & agree to abide by ATTACH's:

- Standards of Practice
- Safety Principles
- Basic Assumptions

I understand if I fail to abide by these principles the ATTACH Ethics Committee may conduct an investigation, and could request my resignation from ATTACH or recommend another disciplinary action.

I give permission to ATTACH to publish my/our name and treatment protocol on the ATTACH website.

I give ATTACH permission to distribute my/our treatment protocol to inquiries for clinical services.

I attest to the veracity of all statements made in my application.

Printed Name of employee _____	
Name of registered agency _____	
Title _____	
Signature _____	Date _____



# Treatment Techniques

Name \_\_\_\_\_

Check as appropriate:

always frequently occasionally never refer out for this service

acceptance rituals					
acupuncture					
adults lay on child					
animals					
behavior management					
blanket wrap					
bottle					
brain gym					
cause physical discomfort					
clay art					
cranial-sacral					
DDP ***					
deliberately frighten					
drawings					
dream work					
EMDR ***					
forgiveness rituals					
home visits					
homeopathy					
homework for child					
homework for parent					
humor					
"in your face" confrontation					
journaling					
letters from birthparents					
marital therapy					
massage					
music					
narratives					
Neurofeedback ***					
nurturing by parents					
nutrition					
parent education					

# Treatment Techniques, page 2

Name \_\_\_\_\_

Check as appropriate:	always	frequently	occasionally	never	refer out for this service
parent holding					
parent observe from another room					
parent present in session					
parent support group					
play therapy					
psychodrama					
puppets					
sand tray					
sensory integration					
separate parent counseling					
separate treatment for parents					
sessions for siblings					
therapist holding					
Theraplay ***					
verbal contract					
video review with family					
written contract					
other					

\*\*\* If you have listed Sensory Processing, SandPlay, Sound Therapy, DIR/Floortime, DDP, EMDR, Neurofeedback or Theraplay as a treatment modality that you use in your practice, please provide proof of training with your application.

This form is to be filled out by each individual clinician in a Registered Clinic.  
[www.ATTACH.org](http://www.ATTACH.org) (612) 821-2351 [questions@attach.org](mailto:questions@attach.org)

# Malpractice Questionnaire

***(To be completed by each qualified therapist in an applicant agency)***

Have you ever had a complaint filed against you?

- If no, check here and sign bottom of form.**
- If yes, check here and fill out remainder of form.

1. Please attach a copy of the original complaint with the settlement and/or court documents.

***Please white out your patient/s name and other identifying information to protect their confidentiality.***

2. Title of Suit

\_\_\_\_\_

3. Date filed

\_\_\_\_\_

4. What are the ***specific*** malpractice charges/allegations?

5. Indicate your ***position*** in the case in relation to plaintiff and to any co-defendants.

6. Provide a brief clinical summary of the case including details of the treatment such as presenting complaints, assessment, diagnosis, medications prescribed, nature of clinical interactions, length of stay, details of discharge, etc.

7. What is your ***response*** to the allegations?

8. Disposition:

- Pending
- Settled

*If settled, provide the following information*

- In court
- Out of court

Date of Settlement \_\_\_\_\_

Total amount of settlement \_\_\_\_\_ Amount attributable to you \_\_\_\_\_

9. Describe any action you have taken, and how your policies and procedures have changed as a result of this claim.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Disciplinary Disclosure Statement

(To be completed by each qualified therapist in an applicant agency)

## **Professional Liability Claims:**

Have you ever been denied professional liability coverage? yes no

Has your professional liability coverage ever been terminated by action of the insurance company? yes no

Has your professional liability carrier excluded any specific procedures from your coverage or otherwise restricted your practice or coverage? yes no

**\*\*\*If you answered yes to any of the above, please provide a detailed explanation on a separate sheet.**

Have there been, or are there currently pending, any malpractice claims, lawsuits, settlements or arbitration proceedings involving your professional practice? yes no

Have you been named as a defendant or accused of discrimination or harassment in any employment related complaint, administrative proceeding, or lawsuit? yes no

**\*\*\*If you answered yes to either of the above, please complete the Malpractice Questionnaire for each case.**

## **Disciplinary Actions:**

Has your license to practice in any state been denied, limited, suspended, revoked, or been voluntarily or involuntarily surrendered, either as a result of an investigation of your activities or in settlement or compromise of such an investigation or because proceedings were threatened or initiated against you? yes no

Have you been denied membership or subject to any disciplinary action in any HMO, or other institutional healthcare provider, local, state or national professional society, or have any such proceedings to revoke, suspend, modify or restrict been instituted against you? yes no

Have you been suspended, sanctioned or otherwise restricted or denied from participating in any private, federal or state health insurance program (such as Medicaid, Medicare)? yes no

Have you been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? yes no

Have you been convicted of a crime, excluding minor traffic violations, whether or not a sentence was imposed? yes no

Have you been the subject of any professional misconduct proceedings (other than malpractice claims)? yes no

Has any disciplinary action been initiated or is any pending against you by any state licensure board? yes no

Has any request for corrective action or investigation (other than normal quality assurance reviews) involving your clinical practice, competence or professional conduct been initiated by any hospital, medical staff or other medical organization, or is any such action currently pending? yes no

**\*\*\*If you answered yes to any of the above, please provide a detailed explanation on a separate sheet.**

Signature\_\_\_\_\_

Date\_\_\_\_\_



## Key for Qualifications of Staff

**Name:** Complete a separate sheet for each qualified therapist. Please designate the lead therapist.

**Level of Practice:**

**1:** A therapist/agency in general practice who is knowledgeable about attachment theory and applies this theory to clients with mild symptoms.

**2:** A therapist/agency with broad training and experience, some of which is in attachment, who sees clients with mild to moderate symptoms, and uses a variety of techniques and modalities for treatment.

**3:** A therapist/agency with extensive training and experience, who has a specialized attachment practice, and provides therapy using a variety of advanced techniques with clients with moderate to severe symptoms.

**Typical client age as it relates to your attachment work:**

**0-1 years**

**2-5 years**

**6-12 years**

**13-17 years**

**18+ years**

**Level of severity as it relates to your attachment work:**

**1:** mild

**2:** moderate

**3:** complex

**4:** extreme

**Training Type:**

**Didactic**

**Hands-on**

**Supervision**

**Minimum Training Requirements for registered clinicians or LEAD therapists:**

- ◆ Masters or Doctoral degree in clinical field
- ◆ 80 hours of attachment theory and treatment training beyond degree, acquired within past 5 years (contact the Chair of the Registration Committee for exceptions for teachers, trainers, etc.)
- ◆ 3 years of clinical experience
- ◆ 30 hours of attachment training for 3-Year Renewals