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| **Applicant:** **Please pass this reference to each of your chose referees, ask them to complete it and post it directly to us.** |

**Reference for:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicants Name:** | **First Name:** | Enter first name | **Surname:** | Enter surname |
| to begin training on a **Certificate in Counselling**. |

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| How long have you know the applicant and in what capacity? |
| Please enter your response here |

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| What qualities has the applicant demonstrated that suggest they are ready, willing and able to pursue this training? |
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| What limitations of the applicant do you consider we should bear in mind when considering their application? |
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| Would you recommend this applicant for training to become a professional counsellor? |
|       |

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| Name of referee: | Enter referee name | Signature: |       | Date: | Enter date |
| Position/Qualification (as applicable): |       |
| Address: | Enter address | Post code: | Enter post code |
| Telephone Number: |       |

Please return to: KMPT.inter-psyche@nhs.net or alternatively send to: Centre Administrator, Inter-Psyche Training Institute, Kent and Medway NHS & SCPT, Trinity Resource Centre, High Street, Dartford DA1 1DE