HOLOGRAPHIC MEMORY RESOLUTION®

DOCUMENTATION

FOR CERTIFICATION

APPLICANT'S NAME: (Please Print) _____

PLEASE MAIL/EMAIL COMPLETED APPLICATION TO: **BRENT M. BAUM**
5675 N. CAMINO ESPLENDORA #6137
TUCSON, AZ 85718

E-MAIL: **ABUNAH@COMCAST.NET**

INSTRUCTIONS

A. Please note that all information contained within this document is CONFIDENTIAL and will only be utilized as a tool to determine appropriateness for certification in HMR. The questions and information provided are intended to serve as resources for both the applicant and the certifying institution, providing opportunities for self-assessment and for identifying the strengths and weaknesses in the applicant's training process.

B. The following documents are to be completed, signed and dated:

1. **General Information forms, including: Personal information, professional data, health status, education, internship record, professional training, supervision and practicum record, licensure and certifications, legal information, malpractice information.**

2. **If you are not a licensed professional, you are required to submit three letters of reference from individuals (Helping Professionals preferred) familiar with you and your practice of HMR. These are to be submitted in sealed envelopes at the time of submission of this application.**

3. **Ethical Statement: HMR Professional Code of Ethics**

4. **Ethics Self-Assessment**

5. **Training-Skills Assessment**

6. **Statement of Intention**

7. **Case Documentation Record: Listing of the 90 Documented successful reframed memories (or memory sequences) utilizing HMR. Client number/initials and dates of sessions are alone recorded on this form.**

8. **Record of Personal Experience of HMR. 10 hours of personal HMR therapy are required and must be acquired through a Certified HMR Practitioner. The "Healing Intensive" accounts for half (5) of the 10 hour requirement.**

9. **Liability/Copyright Acknowledgment.**

C. Upon completion of the above documentation, the written exam (at the end of this document) is to be submitted. An oral exam will be subsequently scheduled (1.5 hour duration). The Oral Exam will be based upon the submitted documentation, the completed (take home) written exam, and the 90 individual cases submitted.

D. A one-time processing fee of $240 is to be submitted at the time of the application and written exam completion. Upon reception and review of all documentation, the oral exam will be scheduled. (Please make checks payable to: "Healing Dimensions ACC" – Credit cards are also accepted.

GENERAL INFORMATION

PERSONAL DATA:

(PLEASE PRINT OR TYPE; MARK N/A WHERE QUESTION IS NOT APPLICABLE)

NAME: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

BIRTH DATE: / / PLACE OF BIRTH: _____ **CITIZENSHIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

E-MAIL ADDRESS: _____ **FAX:** _____

MARITAL STATUS: _____**PARTNER'S NAME:** _____

CURRENT EMPLOYER: _____

PROFESSIONAL DATA:

CURRENT OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

OCCUPATION IF SELF-EMPLOYED: _____

ARE THERE LIMITATIONS TO YOUR PRACTICE OF HMR DUE TO STATE REGULATIONS OR LIMITATIONS OF YOUR PROFESSIONAL LICENSURE? _____

ARE YOU ABLE TO EMPLOY HMR WITHIN YOUR CURRENT WORK ENVIRONMENT? (IF APPLICABLE, EXPLAIN)

_____

ARE YOU USING HMR AS A PROFESSIONAL OR VOLUNTEER WITH ANY SPECIFIC POPULATIONS/AGE GROUPS? _____

_____

HEALTH STATUS:

NOTE: <u>THIS FORM IS CONFIDENTIAL</u>. ITS PURPOSE IS TO IDENTIFY ANY ISSUES OR PROBLEMS THAT COULD IMPAIR THE PRACTICE OF HMR IN YOUR CURRENT LIFE OR RESULT IN A COMPROMISE OF THE CLIENT-FACILITATOR RELATIONSHIP.

(CIRCLE OR SELECT ONLINE THE APPROPRIATE ANSWER; IF YOU RESPOND "YES" TO A QUESTION, BE PREPARED TO OFFER YOUR REFLECTIONS ON THE RELATED CIRCUMSTANCES INSOFAR AS THEY COULD IMPACT YOUR PRACTICE OF HMR.)

HAVE YOU EVER BEEN HOSPITALIZED DURING YOUR PROFESSIONAL WORK HIST.? (Yes ☐ / No ☐)

HAVE YOU EVER BEEN DENIED HEALTH, LIFE, OR DISABILITY INSURANCE? (Yes ☐ / No ☐)

DO YOU HAVE ANY LIMITATIONS ON YOUR HEALTH, LIFE, OR DISABILITY INS.? (Yes ☐ / No ☐)

ARE YOU CURRENTLY UNDER ANY LIMITATIONS RE: YOUR ACTIVITIES/WORKLOAD? (Yes ☐ / No ☐)

ARE YOU CURRENTLY TAKING ANY MEDICATIONS THAT MAY AFFECT EITHER YOUR CLINICAL/THERAPEUTIC JUDGMENT OR MOTOR SKILLS? (Yes ☐ / No ☐)

ARE YOU CURRENTLY ON ANY ANTI-ANXIETY MEDICATION OR ANTIDEPRESSANTS? (Yes ☐ / No ☐)

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR PHYSICAL OR MENTAL PROBLEMS OR STRESS? (Yes ☐ / No ☐)

HAVE YOU EVER HAD ANY PROBLEMS WITH ALCOHOL OR DRUG DEPENDENCY? (Yes ☐ / No ☐)

ARE YOU CURRENTLY INVOLVED OR, IN THE PAST, BEEN ACTIVE IN A 12-STEP SUPPORT GROUP OF ANY NATURE? (OPTION TO DISCLOSE TYPE: _____) (Yes ☐ / No ☐)

DO YOU HAVE ANY PHYSICAL OR MENTAL CONDITIONS WHICH COULD AFFECT YOUR ABILITY TO EXERCISE GOOD CLINICAL/THERAPEUTIC JUDGMENT WHICH IS REQUIRED IN THE TREATMENT OF TRAUMA SURVIVORS? (Yes ☐ / No ☐)

DO YOU HAVE ANY CURRENT COMPULSIVE OR ADDICTIVE PATTERNS THAT COULD INTERFERE WITH YOUR CAPACITY TO REMAIN OBJECTIVELY PRESENT WHEN ADDRESSING THE TRAUMA EXPERIENCES OF A CLIENT? (Yes ☐ / No ☐)

HAVE YOU EXPERIENCED OTHER THERAPEUTIC MODALITIES FOR THE TREATMENT OF TRAUMATIC EXPERIENCES IN YOUR LIFE? (Yes ☐ / No ☐)

DO YOU HAVE ANY OTHER HEALTH CONCERNS THAT COULD RESTRICT YOUR PRACTICE OF HMR? (Yes ☐ / No ☐)

APPLICANT'S NAME: _____ DATE: / /

EDUCATIONAL DATA:

A. LEVEL OF EDUCATION ATTAINED: (SELECT ONE)

☐ **HIGH SCHOOL (/EQUIV.)** ☐ **COLLEGE (GRADUATE)** ☐ **POST-GRAD.: MASTERS** ☐ **PH.D.**

B. EDUCATIONAL HISTORY: (FROM HIGH SCHOOL THROUGH POST-GRADUATE)

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

INSTITUTION: _____

LOCATION AND DATES: _____

DEGREE COMPLETED: _____

C. <u>INTERNSHIPS/EXTERNSHIPS</u> (INCLUDE CLINICAL TRAINING & ND/MD RESIDENCY):

INSTITUTION: _____

LOCATION AND DATES: _____

TYPE OF INTERNSHIP: _____

SUPERVISOR: _____

INSTITUTION: _____

LOCATION AND DATES: _____

TYPE OF INTERNSHIP: _____

SUPERVISOR: _____

INSTITUTION: _____

LOCATION AND DATES: _____

TYPE OF INTERNSHIP: _____

SUPERVISOR: _____

APPROXIMATE NUMBER OF HOURS INVOLVING USE OF SUPERVISED HMR: _____ **HOURS.**

NUMBER OF DOCUMENTED HMR INTERNSHIP HOURS: _____ **HOURS.**

(THE LATTER SHOULD BE CONFIRMED IN CASE DOCUMENTATION/SUMMARY)

DOCUMENTED CLINICAL OR RESIDENCY HOURS UTILIZING HMR: _____ **HOURS.**

ADDITIONAL COMMENTS OR EXPLANATION:

_____

_____

_____

_____

_____

_____

D. <u>ADDITIONAL TRAINING & CERTIFICATIONS</u>: (INCLUDE HERE SPECIALIZED CERTIFICATIONS AND TRAINING SUCH AS SUBSTANCE ABUSE COUNSELING, CLINICAL HYPNOTHERAPY, HEALING TOUCH, MASSAGE, POLARITY, REIKI (WITH CERTIFICATES PROVIDED), ACUPUNCTURE, ETC., FOCUSING ON SKILLS DEVELOPMENT IN THE HEALTH AND ALTERNATIVE HEALING FIELDS.)

INSTITUTION: ______________________________

DATES AND LOCATION: ______________________________

INSTRUCTOR: ______________________________

LICENSE/CERTIFICATION ATTAINED: ______________________________

IS THIS CERTIFICATION CURRENT: (YES ☐ / NO ☐) EXPIRATION DATE: / /

CONTACT NUMBER (IF AVAILABLE): ______________________________

INSTITUTION: ______________________________

DATES AND LOCATION: ______________________________

INSTRUCTOR: ______________________________

LICENSE/CERTIFICATION ATTAINED: ______________________________

IS THIS CERTIFICATION CURRENT: (YES ☐ / NO ☐) EXPIRATION DATE: / /

CONTACT NUMBER (IF AVAILABLE): ______________________________

INSTITUTION: ______________________________

DATES AND LOCATION: ______________________________

INSTRUCTOR: ______________________________

LICENSE/CERTIFICATION ATTAINED: ______________________________

IS THIS CERTIFICATION CURRENT: (YES ☐ / NO ☐) EXPIRATION DATE: / /

CONTACT NUMBER (IF AVAILABLE): ______________________________

INSTITUTION: ______________________________

DATES AND LOCATION: ______________________________

INSTRUCTOR: ______________________________

LICENSE/CERTIFICATION ATTAINED: ______________________________

IS THIS CERTIFICATION CURRENT: (YES ☐ / NO ☐) EXPIRATION DATE: / /

CONTACT NUMBER (IF AVAILABLE): ______________________________

E. <u>PASTORAL/SPIRITUAL TRAINING & CERTIFICATIONS</u>:

ARE YOU LICENSED OR AFFILIATED WITH ANY SPIRITUAL SOCIETY, CHURCH OR ORGANIZATION THAT PERMITS THE "LAYING ON OF HANDS" OR THE PRACTICE OF HMR WITHIN THEIR MINISTERIAL SCOPE? (YES ☐ / NO ☐)

CHURCH/ORGANIZATION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE/FAX: _____

TITLE: (EX: REV., DR., FATHER, SISTER) _____

CONTACT PERSON FOR VERIFICATION: _____

ADDRESS/PHONE OF CONTACT: _____

DO YOU HAVE A FORMAL CERTIFICATION FROM YOUR CHURCH OR SPIRITUAL COMMUNITY TO PRACTICE "HANDS ON HEALING" OR "HMR AS A SPIRITUAL SERVICE TO THE COMMUNITY AT LARGE? (Y☐) IF YOU ALREADY HAVE A CURRENT, VALID MINISTER'S LICENSE OR MINISTERIAL PERMIT, PLEASE DESCRIBE BELOW:

CHURCH/ORGANIZATION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE/FAX: _____

TITLE: (EX: REV., DR., FATHER, SISTER) _____

CONTACT PERSON FOR VERIFICATION: _____

ADDRESS/PHONE OF CONTACT: _____

F. <u>SUPERVISION AND PRACTICUM DOCUMENTATION</u>:

HAVE YOU PARTICIPATED IN A REGULAR HMR PRACTICE GROUP OR SUPERVISION SESSIONS IN YOUR REGION? (Y / N) IF YES, LIST DATES AND THE AMOUNT OF TIME SPENT IN THE PRACTICE OF HMR. <u>NINE HOURS OF GROUP OR 1:1 SUPERVISION ARE REQUIRED FOR CERTIFICATION</u>.

DATE:	AMOUNT OF TIME:	LOCATION:	PRACTICE OR SUPERVISION?	SUPERVISOR OR COORDINATOR:
TOTAL HOURS:				

HMR TRAINING CERTIFICATES:

A. LIST THE DATES AND LOCATIONS OF ALL HMR TRAININGS:

LICENSE TYPE	LOCATION	DATES ATTENDED	TRAINER
LEVEL 1-2 HMR CERTIFICATE			
HEALING INTENSIVE			
LEVEL THREE HMR CERTIFICATE			
ONE-DAY PRACTICUM			
REPEATS:			

B. PLEASE ANSWER THE FOLLOWING QUESTIONS. IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," PLEASE PROVIDE A FULL EXPLANATION OF THE DETAILS IN A SEPARATE COMMUNICATION AND INCLUDE WITH THE APPLICATION.

	YES	NO
HAVE ANY DISCIPLINARY ACTIONS BEEN INITIATED OR ARE ANY PENDING AGAINST YOU BY ANY STATE OR PROFESSIONAL LICENSURE BOARD?	☐	☐
HAS YOUR LICENSE/CERTIFICATION IN ANY JURISDICTION EVER BEEN DENIED, LIMITED, SUSPENDED, OR REVOKED (OTHER THAN FOR NON-PAYMENT OF FEES)?	☐	☐
HAS ANY PROFESSIONAL/CERTIFYING ORGANIZATION OR INSTITUTION FOUND CAUSE TO PLACE YOU ON A PROBATIONARY STATUS OR RESTRICTED YOUR PRACTICE?	☐	☐

APPLICANT'S NAME: _____ **DATE:** / /

LEGAL ACTIONS:

HAVE ANY PROFESSIONAL LIABILITY SUITS EVER BEEN FILED AGAINST YOU? (YES ☐ / NO ☐)

HAVE YOU EVER BEEN NAMED AS A DEFENDANT IN ANY CRIMINAL PROCEEDINGS? (YES ☐ / NO ☐)

HAVE YOU EVER BEEN CONVICTED OF A FELONY? (YES ☐ / NO ☐)

MALPRACTICE INFORMATION:

DO YOU CURRENTLY HOLD MALPRACTICE INSURANCE? (YES ☐ / NO ☐)

IF SO, DETAIL THE INFORMATION BELOW:

COMPANY:

ADDRESS:

HAVE YOU EVER BEEN DENIED LIABILITY/MALPRACTICE INSURANCE COVERAGE? (YES ☐ / NO ☐)

(IF YOU ANSWERED AFFIRMATIVELY TO ANY OF THE ABOVE QUESTIONS, PLEASE DETAIL INFORMATION AND ATTACH TO THIS APPLICATION.)

IF YOU ARE CERTIFIED IN HMR, HAVE YOU GIVEN DUE CONSIDERATION TO THE NEED FOR MALPRACTICE INSURANCE? (YES ☐ / NO ☐)

IF YOU ARE PURSUING MALPRACTICE INSURANCE AS A SCHOOL COUNSELOR, CLERGY OR PASTORAL COUNSELOR, SELF-EMPLOYED COUNSELOR, CERTIFIED HYPNOTHERAPIST, PSYCHOLOGIST OR PSYCHOANALYST, YOU MAY WISH TO CONTACT: EXECUTIVE RISK INDEMNITY INC.

ADMINISTRATIVE OFFICES: SIMSBURY, CT 06070

ADMINISTERED BY: AMERICAN PROFESSIONAL AGENCY, INC.

95 BROADWAY

AMITYVILLE, NY 11701 PHONE: (631) 691-6400 OR (800) 421-6694

APPLICANT'S NAME: _____ DATE: / /

REFERENCES: **(NOT REQUIRED if you can show an active license as CADC, MSW, LCSW, LPC, MFT, Psy.D, Ph.D., M.D., etc., or a professional equivalent and are maintaining your credentials)**

LIST THREE REFERENCES FROM INDIVIDUALS (PREFERABLY "HELPING PROFESSIONALS" WHO ARE FAMILIAR WITH YOUR PRACTICE OF HMR):

1. **NAME:** _____

   ADDRESS: _____

   _____

   PHONE: _____

2. **NAME:** _____

   ADDRESS: _____

   _____

   PHONE: _____

3. **NAME:** _____

   ADDRESS: _____

   _____

   PHONE: _____

(SEALED LETTERS OF RECOMMENDATION FROM THE ABOVE THREE INDIVIDUALS MUST BE SUBMITTED WITH THIS APPLICATION FOR THOSE WITHOUT LICENSURE.)

ETHICAL STATEMENT:

PROFESSIONAL CODE OF CONDUCT

1. **DEDICATION IN ALL EFFORTS TOWARD THE PRIMARY GOAL OF RECOVERY AND EMPOWERMENT OF THE CLIENT.**
2. **RESPECT FOR THE CONFIDENTIALITY OF ALL RECORDS, MATERIALS, AND COMMUNICATIONS CONCERNING CLIENTS.**
3. **RESPECT FOR THE CLIENT BY MAINTAINING AN OBJECTIVE, NON-POSSESSIVE, PROFESSIONAL RELATIONSHIP AT ALL TIMES.**
4. **NO DISCRIMINATION AMONG CLIENTS OR PROFESSIONALS ON THE BASIS OF RACE, COLOR, CREED, AGE, SEX, OR SEXUAL ORIENTATION.**
5. **RESPECT FOR THE RIGHTS AND VIEWS OF OTHER COUNSELING PROFESSIONALS.**
6. **RESPECT FOR INSTITUTIONAL POLICIES AND COOPERATION WITH MANAGEMENT FUNCTIONS IN HEALTH CARE FACILITIES, INCLUDING INITIATIVE TOWARD IMPROVING INSTITUTIONAL POLICIES AND MANAGEMENT FUNCTIONS.**
7. **EVIDENCE OF A GENUINE INTEREST IN HELPING INDIVIDUALS WITH TRAUMA, AND DEDICATION TO HELPING THEM HEAL THEMSELVES AS MUCH AS POSSIBLE.**
8. **WILLINGNESS TO ASSESS ONE'S OWN PERSONAL AND VOCATIONAL STRENGTHS AND LIMITATIONS, BIASES, AND EFFECTIVENESS: ABILITY AND WILLINGNESS TO RECOGNIZE WHEN IT IS IN THE CLIENT'S BEST INTEREST TO REFER OR RELEASE HIM/HER TO ANOTHER INDIVIDUAL OR PROGRAM.**
9. **WILLINGNESS TO TAKE PERSONAL RESPONSIBILITY FOR CONTINUED PROFESSIONAL GROWTH THROUGH FURTHER EDUCATION AND TRAINING.**
10. **TOTAL COMMITMENT TO PROVIDING THE HIGHEST QUALITY OF CARE THROUGH BOTH PERSONAL EFFORT AND THE UTILIZATION OF ANY OTHER HEALTH PROFESSIONALS OR SERVICES WHICH MAY ASSIST THE CLIENT IN HIS/HER RECOVERY JOURNEY.**

"I HAVE READ AND I SUBSCRIBE TO THIS PROFESSIONAL CODE OF CONDUCT. I AGREE TO SURRENDER MY CERTIFICATE IF NECESSARY FOR VIOLATION OF THE PROFESSIONAL CODE OF CONDUCT."

I UNDERSTAND AND AGREE TO THE ETHICAL STANDARDS REQUIRED OF CERTIFIED HMR PRACTITIONERS:

I AGREE: ☐ **I DISAGREE:** ☐ **DATE: / /**

ETHICS SELF-ASSESSMENT:

(THIS SELF-ASSESSMENT IS SIMPLY A TOOL FOR YOUR OWN PERSONAL REFLECTION, DESIGNED TO ASSIST YOU IN REFLECTION UPON ISSUES THAT COULD FIGURE SIGNIFICANTLY INTO THE EFFECTIVENESS OF YOUR PRACTICE OF HMR. YOU MAY WISH TO DISCUSS ANY RELEVANT CONCERNS WITH YOUR SUPERVISOR.)

HAVE I ADEQUATELY ADDRESSED THE TRAUMA ISSUES OF MY OWN LIFE SO THAT I AM ABLE TO BE PROFESSIONALLY AVAILABLE TO MY CLIENT? (YES ☐ / NO ☐)

AM I TRULY COMMITTED TO THE PROCESS OF EMPOWERMENT OF MY CLIENT AND ABLE TO STILL REMAIN EMOTIONALLY DETACHED FROM MY CLIENT'S OUTCOME OR PROCESS IN A GIVEN SESSION? (YES ☐ / NO ☐)

HAVE I BEEN ABLE TO REMAIN OBJECTIVE, SUPPORTIVE, AND EMOTIONALLY PRESENT DURING MY PRACTICE OF HMR WITHOUT BECOMING DISTRACTED OR CAUGHT UP IN MY OWN PROCESS? (YES ☐ / NO ☐)

DO I STILL HAVE CERTAIN EMOTIONAL OR SOMATIC "TRIGGERS" FROM MY OWN HISTORY THAT SHOULD BE ADDRESSED PRIOR TO WORKING WITH CLIENTS OF SIMILAR BACKGROUNDS? (YES ☐ / NO ☐)

ARE MY PERSONAL BOUNDARIES SUFFICIENT TO CONFRONT CLIENTS WITH SEVERELY DAMAGED BOUNDARIES IN ORDER TO PROVIDE THE SAFETY NEEDED FOR THE RESOLUTION OF TRAUMATIC MEMORY? (YES ☐ / NO ☐)

AM I COMFORTABLE ENOUGH WITH THE HMR STRUCTURE AND CONTENT TO BE OPEN TO THE UNIQUENESS OF EACH CLIENT'S TRAUMA HISTORY WITHOUT THE DISTRACTION OF SELF-DOUBT OR ANXIETY REGARDING MY PERFORMANCE? (YES ☐ / NO ☐)

DO I HAVE ANY AREAS OF COMPULSIVITY, "CODEPENDENCY," OR DISTRUST OF MYSELF THAT SUGGEST UNRESOLVED TRAUMA AND COULD BEAR UPON MY EFFECTIVENESS WITH OR PRESENCE TO A CLIENT? (YES ☐ / NO ☐)

TRAINING/SKILLS ASSESSMENT:

(USE THE FOLLOWING SCALE IN YOUR RESPONSES: 10 DESIGNATES MAXIMUM COMFORT, WHILE 1 DESIGNATES MINIMUM COMFORT. FEEL FREE TO DISCUSS RESPONSES WITH YOUR SUPERVISOR.) 10= MAX……..1=MINIMAL

MY DEGREE OF FAMILIARITY WITH THE CLIENT-CENTERED LANGUAGE OF HMR AND ACCURATE MIRRORING OF THE CLIENT'S RESPONSES:

EFFECTIVE UTILIZATION OF MY VOICE TO FOSTER SAFETY AND FOCUS FOR MY CLIENT DURING THE SESSION:

THE ABILITY TO UTILIZE AND CONTROL MY VOICE TO ANCHOR THE CLIENT IN PRESENT TIME:

MY DEGREE OF COMFORT UTILIZING THE VERBAL TECHNIQUES OF HMR AND READILY ADAPTING THEM TO THE NEEDS OF MY CLIENT:

MY COMFORT IN EMPLOYING THE ENERGY (NERVOUS SYSTEM SUPPORT) TECHNIQUE DURING THE SESSIONS:

THE DEGREE OF ENERGY SENSITIVITY THAT MY HANDS HAVE ATTAINED THROUGH PRACTICE:

MY CAPACITY TO TRACK OR "MAP" THE CLIENT'S MOVEMENT OF MEMORY METAPHORS (FRAGMENTS) THROUGH THE NERVOUS SYSTEM:

MY ABILITY TO ADAPT AND INTEGRATE SPONTANEOUS SOLUTIONS THAT ARISE IN CRITICAL SITUATIONS WITH HMR:

ATTENTIVENESS TO MY OWN SELF-CARE FOLLOWING WORK WITH A CLIENT:

ADDITIONAL COMMENTS: _____

_____

_____

_____

STATEMENT OF INTENTION:

IT IS MY INTENTION TO UTILIZE MY TRAINING/CERTIFICATION IN HMR WITHIN THE FOLLOWING CONTEXTS: (CHECK THOSE APPLICABLE)

☐ **WITHIN MY PROFESSIONAL PRACTICE AS A PSYCHIATRIST, PHYSICIAN, PSYCHIATRIC NURSE PRACTITIONER, OR NATUROPATHIC PHYSICIAN.**

☐ **WITHIN MY PRACTICE AS A PSYCHOLOGIST, MARRIAGE AND FAMILY COUNSELOR, SOCIAL WORKER, PSYCHOTHERAPIST, CLINICAL HYPNOTHERAPIST, SUBSTANCE ABUSE COUNSELOR OR (LICENSED MENTAL HEALTH PROFESSIONAL) OTHER:**

☐ **WITHIN MY PRACTICE OF BODY-CENTERED THERAPY SUCH AS POLARITY, ACUPUNCTURE, MASSAGE, HEALING TOUCH, REIKI, OR OTHER:**

☐ **AS A MINISTER, LAY MINISTER, OR PASTORAL COUNSELOR OF A CHURCH OR SPIRITUAL COMMUNITY/AFFILIATION. INDICATE THE CHURCH OR ORGANIZATION WITH WHICH YOU ARE AFFILIATED:**

☐ **AS A VOLUNTEER OR WITHIN A "NON-REVENUE PRODUCING" CAPACITY WITH NON-PROFIT/ SERVICE ORGANIZATIONS.**

☐ **FOR MY OWN PERSONAL GROWTH AND HEALING AND, WHEN APPROPRIATE, FOR THAT OF FRIENDS, CO-WORKERS AND/OR FAMILY MEMBERS WHO MAY BENEFIT FROM THIS SKILL.**

APPLICANT'S NAME: _____ DATE: / /

CASE DOCUMENTATION RECORD: (NOTE: FOR CERTIFICATION IN HMR YOU ARE REQUIRED TO DOCUMENT 90 MEMORIES OR COMPLETE MEMORY SEQUENCES. CLINICAL RESIDENCY OR FORMALLY SUPERVISED PRACTICE WILL ALSO BE CONSIDERED AS IN THE CASE OF MEDICAL SCHOOLS. CITED CASES SHOULD CORRESPOND TO SUBMITTED DOCUMENTATION.)

CLIENT NO.:	DATE:	CLIENT NO.:	DATE:	CLIENT NO.:	DATE:
1.		31.		61.	
2.		32.		62.	
3.		33.		63.	
4.		34.		64.	
5.		35.		65.	
6.		36.		66.	
7.		37.		67.	
8.		38.		68.	
9.		39.		69.	
10.		40.		70.	
11.		41.		71.	
12.		42.		72.	
13.		43.		73.	
14.		44.		74.	
15.		45.		75.	
16.		46.		76.	
17.		47.		77.	
18.		48.		78.	
19.		49.		79	
20.		50.		80.	
21.		51.		81	
22.		52.		82.	
23.		53.		83.	
24.		54.		84.	
25.		55.		85.	
26.		56.		86.	
27.		57.		87.	
28.		58.		88.	
29.		59.		89.	
30.		60.		90.	

PERSONAL EXPERIENCE OF HMR:

(NOTE: FOR CERTIFICATION IN HMR, TEN (10) HOURS OF PERSONAL EXPERIENCE ARE REQUIRED. THE PURPOSE OF THIS REQUIREMENT IS BOTH TO FACILITATE UNDERSTANDING OF THE DYMAMICS AND EFFECTS OF HMR, ALSO TO FOSTER SELF-HEALING IN THE PRACTITIONER SO AS TO RESOLVE THE TRAUMA TRIGGERS THAT COULD LEAD TO "COUNTER-TRANSFERENCE" WITH CLIENTS. ATTENDANCE AT THE "HEALING INTENSIVE" ACCOUNTS FOR HALF (5) OF THE REQUIRED (10) HOURS AND IS A REQUIREMENT FOR CERTIFICATION.)

APPLICANT'S NAME:

DATE	**PRACTITIONER OF HMR**	**LENGTH OF SESSION**
(REQUIRED)		**5 Hours: Healing Intensive**

APPLICANT'S NAME: _____ **DATE: / /**

LIABILITY AND COPYRIGHT ACKNOWLEDGMENT:
LIMITATIONS OF MATERIAL USE

I understand that Holographic Memory Resolution® involves an instructional empowerment process whereby individuals are taught and implement the basic principles of emotional reframing. In accepting training and moving toward certification in HMR, I acknowledge the importance of communicating the principles of HMR accurately to clients/participants in the process. I agree to communicate to the best of my ability the principles as delivered in formal training in HMR and to follow the curriculum and ethical directives which are designed to prevent re-traumatization, relive, and abreaction. I understand that the unauthorized modification or misapplication of the core principles, protocols and interventions of HMR can result in the revocation of certification by Healing Dimensions ACC. Damage or injury to clients through inappropriate or re-traumatizing interventions could result in liability for Healing Dimensions ACC; hence, I acknowledge that Healing Dimensions ACC is not liable for unauthorized divergence from the training curriculum and therapeutic protocols or therapeutic interventions that exceed the ethical parameters of my licensure/certification. Certification in HMR indicates that I have achieved a basic level of proficiency in the all three levels of training and the principles of HMR. Maintenance of certification means that I will also avail myself at least every 5 years of the latest updates in the application of HMR to various populations. I agree to refrain from the formal training or instruction of others in HMR without the appropriate "Trainer Certification" and the fulfillment of HMR Trainer requirements. While other skills and modalities can be integrated at appropriate times into the fundamental structure of HMR, I agree to honor the integrity of HMR and utilize the language and principles as closely as possible in keeping with the guidelines presented during training. I agree to seek written permission for the replication of any written or visual materials utilized in HMR trainings, but also understand that I am encouraged to disseminate the principles of HMR and to educate the public on the basic principles and dynamics of trauma induction and resolution. In the written and oral delivery of these principles I will use appropriate citations and acknowledgments. I recognize that HMR and all instructional materials are the copyrighted property of Healing Dimensions ACC and Brent Baum, its Director.

Signature of Trainee: _____

Date: / /

EXAM INSTRUCTION:

WRITTEN EXAM: THE WRITTEN EXAM IS A "TAKE HOME" EXAM BASED ON A SERIES OF 50 AREAS OF ENQUIRY. YOU ARE ENCOURAGED TO ANSWER THE QUESTION EFFECTIVELY BUT NOT "EXHAUSTIVELY" IN A WRITTEN FORM. NOTE, HOWEVER, THAT THE ORAL EXAM WILL BE BASED, IN PART, ON THESE SAME QUESTIONS AND THAT A THOROUGH FAMILIARITY WITH THE ISSUES WILL SERVE YOU DURING MORE DETAILED QUESTIONING. BOTH YOU AND THE EXAMINER WILL HAVE A COPY OF YOUR WRITTEN RESPONSES.

ORAL EXAM: THE ORAL EXAM IS BASED ON THE FOLLOWING: YOUR WRITTEN RESPONSES TO THE 50 AREAS OF QUESTIONING, YOUR PERSONAL EXPERIENCE FROM YOUR SUBMITTED CASE WORK, YOUR RESPONSES IN THE APPLICATION FORM AND TO THE VARIOUS ASSESSMENTS INCLUDED IN THE APPLICATION, AND YOUR SUPERVISOR'S PERSONAL EXPERIENCE WITH YOUR TRAINING PROCESS. MAXIMUM TIME REQUIRED: 1.5 HOURS

DEMONSTRATION: YOU WILL BE ASKED TO UTILIZE HMR ON YOUR EXAMINER AND TO ADDRESS A MEMORY/SERIES OF MEMORIES PRESENTED BY THE EXAMINER. THIS WILL LAST NO LONGER THAN 30 MINUTES IN DURATION. YOUR PERFORMANCE WILL BE REVIEWED WITH THE EXAMINER AT THE END OF THIS PRACTICE.

GRADE/OUTCOME: YOUR EXAMINER HOLDS THE FOLLOWING OPTIONS OF RESPONSE: PASS, FAIL, CONDITIONAL PASS (BASED ON THE NEED TO COMPLETE A REQUIRED AREA OF TESTING/DOCUMENTATION/SKILLS DEVELOPMENT FOR FINAL PASS AND ISSUANCE OF CERTIFICATE. THESE ARE NORMALLY RENDERED AT THE CLOSE OF THE ORAL EXAM, BUT MAY BE WITHHELD PENDING THE NEED FOR CLARIFICATION OF CERTAIN ASSESSMENT ISSUES. UPON FAILURE OF THE EXAM, A "RETAKE" WILL BE OFFERED AT NO CHARGE AFTER A PERIOD OF 3 MONTHS AND AFTER FURTHER TRAINING IN THE AREAS OF DEFICIENCY. THE HMR PRATITIONERS CERTIFICATE WILL BE ISSUED ONLY AFTER ALL REQUIREMENTS ARE COMPLETED.