FORM S3

THERAPIST INFORMATION

Name:.....

Surname: .....

Address (Physical Address of consultation Rooms)

.....

.....

Contact Details

Tel: .....

Cell: .....

Fax: .....

Email: .....

1. I, ... do hereby agree to render therapeutic services on behalf of the Western Cape Assoc. for Play Therapy at a reduced price per session
2. I agree to render 6/8 sessions per client at a rate of R..... per session
3. I agree to have my contact details placed on a centralised data base to be kept by the Western Cape Assoc. for Play Therapy
4. I agree to submit my invoice to the Chair Person of the Western Cape Assoc. for Play Therapy after services has been rendered and that payment will be made to me within 30 days after the invoice has been received by the Treasurer
5. Should the client require further therapeutic services, I agree to obtain written permission from the Western Cape Assoc. for Play Therapy Management prior to continuing services
6. I agree to consult with the Social Worker of the client

Signed:.....

Date:.....

WESTERN CAPE ASSOCIATION FOR PLAY THERAPY
WES-KAAP VERENIGING VIR SPELTERAPIE

Website: http://www.association-playtherapy.org.za/
Email: spelterapie@gmail.com