EMDR Application (Cohort 10)

Please complete the EMDR Application below.

SECTION 1 OF 7- APPLICATION INSTRUCTIONS

The EMDR learning collaborative is scheduled for Fall 2026. The course instructor is Carol Miles, LCSW for this training opportunity. The course is limited to fifty (50) clinicians.
The training application requires TWO (2) FORMS to be completed for EVERY APPLICANT, the Trainee Application, AND the Agency Agreement.

Please review the EMDR Request for Applications (RFA) in its entirety for complete details about the training prior to completing an application.

You can click here to access the EMDR RFA:
https://laevidencetopractice.com/wp-content/uploads/2026/07/EMDR_RFA_FALL-2026_FINAL.pdf

The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the EMDR training and signed by the Administrator and Supervisor. You can access the AGENCY AGREEMENT by CLICKING HERE. The AGENCY AGREEMENT MUST BE SUBMITTED THROUGH THE EMDR APPLICATION. The deadline for completion is Monday, August 10, 2026.

BOTH FORMS MUST BE COMPLETED FOR EACH EMDR APPLICANT TO BE CONSIDERED FOR THIS TRAINING OPPORTUNITY

When navigating through this application, please only use the PREVIOUS PAGE and NEXT PAGE buttons on the bottom of the screen. DO NOT utilize the backwards or forwards arrow on the webpage.

SECTION 2 OF 7 - EMDR APPLICANT INFORMATION

This questionnaire is to be completed separately by each potential participant.

(ONE OF THE PREREQUISITES TO HAVE YOUR AGENCY'S APPLICATION CONSIDERED FOR THE EMDR TRAINING IS ACCEPTING MEDICAID AND ACTIVELY TREATING CHILDREN AND ADOLESCENTS)

Applicant First Name: _____

Applicant Last Name: _____

Applicant Job Title: _____

Applicant Phone Number: _____

Applicant Email Address:

_____

(Please verify that your email address is typed correctly.)

What is your NPI number?

_____

What type of agency does the applicant primarily work for?

- ◯ Child Advocacy Center
- ◯ Human Services District/Authority
- ◯ Medical Center (either inpatient or outpatient)
- ◯ Behavioral Health Service Provider (BHSP), providing Mental Health Rehabilitation services
- ◯ Independent Mental Health Practitioner/ Private Practice
- ◯ LMHP Group Practice
- ◯ Other

_____

(Please indicate the type of agency you work at)

Please specify the agency type:

- ◯ Sole practice provider
- ◯ Agency-based provider
- ◯ Both (sole practice provider AND agency-based provider)

What is your employment status with this agency?

- ◯ Full-time
- ◯ Part-time
- ◯ Contract
- ◯ Temporary
- ◯ Other

Please describe.

_____

Are you a Louisiana Medicaid Provider?

- ◯ Yes
- ◯ No

Which MCO plans are you contracted with?

- ☐ Aetna Better Health
- ☐ Amerihealth Caritas of Louisiana
- ☐ Healthy Blue/Anthem
- ☐ Humana Healthy Horizons
- ☐ Louisiana Healthcare Connections
- ☐ Magellan Behavioral Health
- ☐ United Healthcare/Optum
- ☐ Other

(Please select all that apply.)

Please specify.

_____

Is your agency a Child Advocacy Center?

- ◯ Yes
- ◯ No

Please specify what type of entity.

_____

Do you currently see Louisiana Medicaid clients?
- ◯ Yes
- ◯ No

Do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.

_____

Do you see patients in a clinical setting?
- ◯ Yes
- ◯ No

Please list all insurance plans you accept for payment, including Medicare and private health policies.

_____

Are you actively treating children and adolescents?

This is a requirement in order to participate in this training opportunity, If you select, "No" for this question, we recommend that this training opportunity is not a good fit for you at this time.
- ◯ Yes
- ◯ No

Please select which age range best describes the applicant.
- ◯ 20-24 years old
- ◯ 25-34 years old
- ◯ 35-44 years old
- ◯ 45-54 years old
- ◯ 55-59 years old
- ◯ 60 years or older

Which of the following best describes the applicant?
- ◯ Female
- ◯ Male
- ◯ Other

Please specify:

_____

Does the applicant consider themselves to be Hispanic, Latino, or of Spanish origin?
- ◯ Yes
- ◯ No

Which of the following best describes the applicant race?
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Pacific Islander
- ◯ White or Caucasian
- ◯ Multiple races
- ◯ Other

Please specify the applicant race:

_____

Please select the STATE applicant is licensed to practice in
- ◯ LA
- ◯ Other

Please specify which state utilizing 2 letter state abbreviations:

_____

Which of the following region(s) does the applicant provides services to? Check all that apply:

- ☐ Region 1: Jefferson, Orleans, Plaquemines, St. Bernard
- ☐ Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, West Feliciana
- ☐ Region 3: Assumption, Lafourche, St Charles, St. James, St. John, St. Mary, Terrebonne
- ☐ Region 4: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
- ☐ Region 5: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
- ☐ Region 6: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn
- ☐ Region 7: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster
- ☐ Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
- ☐ Region 9: Livingston, St. Helena, St. Tammany, Tangipahoa, Washington
- ☐ Region 10: Jefferson

Of the regions you selected from above, please select the top two (2) regions you serve the most (select NO MORE than 2):

- ☐ Region 1
- ☐ Region 2
- ☐ Region 3
- ☐ Region 4
- ☐ Region 5
- ☐ Region 6
- ☐ Region 7
- ☑ Region 8
- ☐ Region 9

Do you provide telehealth services?

- ◯ Yes
- ◯ No

What is the highest degree completed to date?

- ◯ Bachelor's
- ◯ Master's
- ◯ Doctorate/PhD
- ◯ In Progress

Please specify the degree type obtained

_____

Please specify month and year of completion:

_____
(Please provide month and year)

Please select the credential type that best describes the applicant.

- ◯ Counselor
- ◯ Social Worker
- ◯ Psychologist
- ◯ More than one credential type
- ◯ I have another type of credential
- ◯ I do not hold a credential

Please select your Provisional License/ License Type.

- ◯ PLPC
- ◯ LPC
- ◯ LPC-S
- ◯ PLMFT
- ◯ LMFT

Indicate MONTH and YEAR of licensure or expected licensure	_____
Please enter your LICENSE NUMBER(s) with your respective credential	_____
Please select your Provisional License/ License Type.	◯ CSW ◯ LMSW ◯ LCSW ◯ LCSW-BACS
Indicate MONTH and YEAR of licensure or expected licensure	_____
Please enter your LICENSE NUMBER(s) with your respective credential	_____
Please select your Provisional License/ License Type.	◯ Provisional Licensed Psychologist (PLP) ◯ Licensed Psychologist (LP) ◯ Licensed Specialist in School Psychology (LSSP)
Please enter your LICENSE NUMBER(s) with your respective credential	_____
I hold the following credential:	_____
Please enter your LICENSE NUMBER(s) with your respective credential:	_____
I hold the following credentials (please select all that apply):	☐ PLPC ☐ LPC ☐ LPC-S ☐ PLMFT ☐ LMFT ☐ CSW ☐ LMSW ☐ LCSW ☐ LCSW-BACS ☐ PLP ☐ LP ☐ LSSP ☐ Other
Please enter your LICENSE NUMBER(s) with your respective credential:	_____
Indicate MONTH and YEAR of licensure or expected licensure	_____ (Please indicate month and year)
Please specify:	_____

Are you proficient in any other languages other than English?	◯ Yes ◯ No

Please elaborate.

_____

SECTION 3 OF 7- AGENCY INFORMATION

Name of Applicant Agency	_____
Agency Street Address	_____
Agency City	_____
Agency State	◯ LA ◯ Other
Other (please specify state using 2 lettered abbreviations):	_____
Agency Zip Code	_____
Agency Mailing Address (if different from Agency Street Address)	_____
Agency NPI (if known)	_____

SECTION 4 OF 7- TRAINEE EMDR APPLICATION QUESTIONS. THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT.

Have you previously received training in EMDR?

◯ Yes
◯ No

Please explain WHEN that training took place and for what level regarding EMDR?

_____

Would you have a supervisor that supports you as a practitioner?

◯ Yes
◯ No

Note: The supervisor is welcome to audit the training if they are available and interested.

Would the supervisor be willing to join a supervisory group?

◯ Yes
◯ No

Please explain:

Please limit response to 100 words

_____

Describe your agency's current sources for child referrals. Do you anticipate any challenges in finding children that have a history of trauma?

_____

Please limit response to 100 words.

Describe your experience serving Medicaid children/adolescents and families.

_____

Please limit response to 100 words.

Number of years in clinical work, agency settings, and treatment approaches, etc.

Describe the geographic area and population served at your agency. Additionally, please mention any unique characteristics of this population.
Please limit response to 100 words.

_____

Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive EMDR?
Please limit response to 100 words.

_____

Explain how EMDR would fit your agency/practice and the community you serve.
Please limit response to 100 words.

_____

How many people in your agency/ practice have been EMDR trained and/or EMDR Basic-Trained?

_____

Please limit response to 100 words.

Please list any EBP you completed training in, where you were first trained, and your certification status.

_____

Are you currently in training for other EBP certifications?

◯ Yes
◯ No

When will you complete this training? Please be as specific as possible, including MONTH and YEAR of anticipated completion.

_____

What EBP training are you currently in? Select all that apply.

☐ Parent-Child Interaction Therapy (PCIT)
☐ Positive Parenting Program (PPP)
☐ Trauma Focused- Cognitive Behavioral Therapy (TF-CBT)
☐ Eye Movement Desensitization and Reprocessing (EMDR)
☐ Child-Parent Psychotherapy (CPP)
☐ Pre-School PTSD Treatment (PPT)
☐ Youth PTSD Treatment (YPT)
☐ Functional Family Therapy-Child Welfare (FFT-CW)
☐ Homebuilders
☐ Functional Family Therapy (FFT)
☐ Multi-Systemic Therapy (MST)
☐ Other

Please specify:

_____

What is your current caseload per week? Can you add/utilize the EMDR practice with your current caseload/clients?
Please limit response to 100 words.

_____

SECTION 5 OF 7- IMPLEMENTATION SUPPORT

How many people in your agency have been trained in EMDR?

_____

If chosen for this opportunity, would your agency leadership be interested in attending a ONE, 1-hour EMDR, implementation discussion BEFORE beginning EMDR training with clinicians?

◯ Yes
◯ No

Please provide the FIRST AND LAST NAME(S) of the leadership that would be interested and available to attending the EMDR Implementation Discussions:

_____
(Please input first and last name(s))

Please provide the EMAIL ADDRESS(ES) of the leadership that would be interested and available to attending the EMDR Implementation Discussions:

_____
(Please input emails)

Would your agency leadership also be interested in auditing the EMDR training to better support clinical staff?

◯ Yes
◯ No

Do you perceive any barriers to implementing this EBP within your agency?

◯ Yes
◯ No

Please explain.

Please limit response to 100 words.

_____

How did you hear about the EMDR training opportunity through the Center for Evidence to Practice?

☐ Evidence to Practice (E2P) MailChimp Listserv and/or E2P Direct Email
☐ Director, Supervisor, or Manager
☐ Direct Email Outreach not from E2P
☐ Word of Mouth
☐ Social Media Advertisement
☐ Other
(Select all that apply.)

Please specify how you heard about this training opportunity:

_____

SECTION 6 OF 7: Can the applicant participate in the following training dates?

The Center for Evidence to Practice will be sponsoring one (1) cohort of EMDR training in Fall 2026- Spring 2027. Applicants must be able to commit to and participate in ALL training dates listed below. This is a requirement in order to participate in this training opportunity.

	Yes, I can attend/participate	No, I cannot attend/participate _____
EMDR MANDATORY Orientation Meeting: Thursday, August 27, 2026, from 12:00pm- 1:00pm CDT	○	○
EMDR Learning Session 1 Training: Thursday-Friday & Monday, September 10-11 & 14, 2026, 9:00am-5:30pm CDT	○	○
EMDR Learning Session 2 Training: Thursday-Friday & Monday, November 5-6 & 9, 2026, 9:00am-5:30pm CST	○	○
EMDR Consultation Calls: Ten and a half (10.5) hours of consultation calls	○	○

SECTION 7 OF 7- COMMITMENT FROM CLINICIAN

Please ensure to review each of the following requirements to confirm you are able to participate in the EMDR Training.

By selecting, "Yes, I can commit" below, you commit to do the following:

	Yes, I can commit	No, I cannot commit _____
(1) I will attend all training sessions dates/times: _____	○	○
(2) I will attend Ten and a half (10.5) hours of consultation calls	○	○
(3) I will communicate with my agency/supervisor/leadership if changes need to be made in my caseload to acquire the appropriate cases to implement EMDR	○	○
(4) I will review the REQUEST FOR APPLICATION (RFA) to be aware of training expectations. You can access the EMDR RFA by clicking this link: _____	○	○
(5) I will attend or watch recording of the EMDR informational webinar so I am aware of the training expectations and time commitment. Accessible on our E2P Learn Platform: _____	○	○
(6) I will submit a TRAINEE APPLICATION	○	○
(7) I will submit an AGENCY AGREEMENT on behalf of my agency. You can access the Agency Agreement by clicking this link: _____	○	○

The AGENCY AGREEMENT must be completed and signed through Adobe PDF (a fillable PDF) by a supervisor and/or administrator at the agency requesting participation in the EMDR training. The agency agreement must be completed by Monday, August 10, 2026.

You can click on this link to access the AGENCY AGREEMENT

PLEASE UPLOAD YOUR SIGNED AND COMPLETED AGENCY AGREEMENT FORM HERE.

IF YOU HAVEN'T ALREADY, CLICK HERE TO ACCESS THE AGENCY AGREEMENT FORM

(Please upload signed and filled out agency agreement to the right.)

Please review any of your responses on previous pages before submitting your application.

To receive a PDF copy of your application responses, please type in your E-MAIL ADDRESS in the on the next page.