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| **Teil A: Nachweis der mit EMDR behandelten PatientInnen** | | | | | |
| **Nr.** | **Initialen, Geburtsjahr** | **Thema, Diagnose** | **Anzahl EMDR Sitzungen** | **Behandlungsdauer** | |
| Bsp. | N.N., 1969 | Unfall, PTBS | 12 | 30.10.17-12.11.18 | |
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| Insgesamt mindestens 400 Stunden (zu 60 Minuten) EMDR-Sitzungen? | | | | Ja | Nein |
| Insgesamt mindestens 75 PatientInnen? | | | | Ja | Nein |

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Name der antragstellenden Person in Druckbuchstaben

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Unterschrift der antragstellenden Person Datum

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Name des/der EMDR Europe anerkannten SupervisorIn (Consultant) in Druckbuchstaben

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Unterschrift des/der SupervisorIn (Consultant) Datum