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| **Partie A : Validation des cas client traité Avec EMDR** | | | | | |
| **N°** | **Initiales, année de naissance** | **Thème, diagnostic** | **Nbre séances EMDR** | **Durée du traitement** | |
| Ex. | N.N., 1969 | Accident / TSPT | 12 | 30.10.17-12.11.18 | |
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| Au moins 400 séances d'EMDR de 60 minutes ? | | | | Oui | Non |
| Au moins 75 clients ? | | | | Oui | Non |

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Nom de la personne candidate en lettres majuscules

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Signature de la personne candidate Date

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Nom du superviseur/de la superviseuse accrédité/e EMDR Europe (Consultant) en lettres majuscules

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Signature du superviseur/de la superviseuse (Consultant) Date