



Clinical Musician Certification Program
Modified Requirements Application

Admission and final assessment decisions will be made without discrimination based upon gender, race or religious affiliation. Please note that healthcare institutions usually have a minimum age requirement of 18 to play at the bedside, so age may affect your ability to complete the internship requirement.

Harp for Healing, LLC
920 4th Avenue
Havre, Montana 59501-4506 USA

For additional information:
Email us at harpforhealing@gmail.com or call 406-265-8542

Date: _____

Name: _____

Address: _____

City: _____ State _____ Zip _____

Telephone _____ Country _____

Email _____

The program office will share your contact information with your mentor, but does not share contact information with anyone else without your permission.

What instrument(s) do you play? _____

How do you rate your skill level? (check one) Beginner Intermediate
 Advanced



Please describe your background including your education, training and any credentials. Please include information about any healthcare, hospice, complementary healthcare or spiritual training or experience.

Have you already experienced bedside playing? Please describe _____

What is your objective in taking this program? _____

How did you hear about this program? _____

As a Certified Clinical Musician, I agree to conduct myself in accordance with the following principles:

Patient Welfare and Confidentiality:

I will focus on the welfare of the patient above all else in a compassionate and non-judgmental manner. Services will be offered only in settings that ensure safety for both the patient and myself. I will hold all patient information and records, and all information observed or shared in my presence, confidential according to Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requirements.

Competence and Qualifications:

I will perform only those duties for which I have been adequately trained, not engaging in practices outside of my area(s) of competence. I will state my qualifications, titles, and professional affiliation(s) accurately and work within the scope of practice of therapeutic musicians (unless licensed or qualified, and hired/approved to do additional therapies in conjunction with therapeutic music work). If I am referred to incorrectly, I will take appropriate steps to correct any misrepresentation. I will seek appropriate assistance when needed and I will avoid making any predictions or claims about the efficacy of the services that I offer.

Respect:

I will respect the rights of others to hold values, attitudes, cultural traditions, musical preferences, religious beliefs, political perspectives, and opinions that differ from my own. During a therapeutic music session I will speak of my own personal opinions, traditions, perspectives, and beliefs only when asked by the client or responsible family members and only if appropriate to the situation.

Practice and Personal Awareness:

I will practice with integrity, honesty, fairness and respect for others. I will not engage in any type of discriminatory or exploitive relationship(s). I will report any serious ethical violations that I have observed to the appropriate agency or persons. If I become aware of my own personal limitations, problems, or values that might interfere with my professional work I will take whatever action is necessary (e.g., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems.

Deportment:

I will use my best professional judgment, interpersonal skills, and etiquette when interacting with patients, families, and hospital staff. My appearance and dress will be appropriate, professional and respectful. Any public statements that I release will be truthful and objective, and will protect the proprietary interests of patients and professional colleagues.

Self-Interest:

I will avoid actions that promote self-interest at the expense of the profession, and I will uphold the standards of my employer/contractor with honor and dignity. I will accept appropriate compensation only for services actually rendered by myself.

Permission:

I will obtain the patient's or family/caregiver's permission or obtain permission from facility staff members for a therapeutic music session.

Camaraderie:

I will work harmoniously to the best of my ability with nurses, physicians, therapeutic musicians, colleagues and other members of the patient's health care team and staff in those facilities where I serve. I will not knowingly damage the professional reputation or practice of others.

Continuing Education:

I will strengthen my abilities as a Therapeutic Musician through continuing practice and education. I will strive to increase my level of knowledge and skills and promote research within the profession.



Clinical Musician Certification Program Student Agreement

I agree that I will review the course materials, graduation requirements, and expectations of students, mentors and the program upon receipt. If I decide not to pursue the program after reviewing the materials and I return all the materials in new condition to the course office within 20 days, I will receive a refund of my payment less a processing fee of \$100.

I understand that the course materials are copyrighted and may not be copied or shared with anyone not registered in the program. I agree that I will not inappropriately use the program's copyrighted materials, nor will I teach these materials to others.

I have read the Certified Clinical Musician Code of Ethics & Conduct and agree, as a student or graduate of the Clinical Musicians Certification Program, to conduct myself in accordance with the Certified Clinical Musician Code of Ethics & Conduct.

I understand that the program may modify completion requirements to meet NSBTM standards and that I may be subject to revised requirements if I have not completed the program for which I am registered within three years. I understand that I will have a mentor assigned and that it is my responsibility to work with my mentor openly.

I understand my mentor and the program office are available to answer questions regarding program materials and requirements.

I agree that the program office may share my contact information with my assigned mentor.

Please check the box to indicate you have read and agree to the terms stated above.
mentor.

Student's Printed Name _____

Student's Signature _____ Date _____

Thank you for applying to Harp for Healing's Clinical Musician Certification Program (CMCP). Your submitted application and recording will be reviewed as quickly as possible. You will be notified by email when that review is complete.

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Havre, Montana 59501-4506 USA