

**The Center for Psychoanalytic Training and Research
1051 Riverside Drive
New York, New York 10032**

***Application for Admission
PARENT-INFANT PROGRAM***

Instructions: 1. Please write legibly in ink. 2. Attach your check or money order for \$50 payable to *Columbia University*, where specified below: this fee covers part of the cost of processing your application and therefore is not refundable. 4. Mail to the *Center for Psychoanalytic Training and Research, 1051 Riverside Drive, Box 63, New York, N.Y. 10032*.

Date _____

1. Name _____ Degree _____
Last First Middle

2. Present Mailing/Office Address _____
_____ Telephone _____
City State Zip Code

3. Permanent Home Address _____
_____ Telephone _____
City State Zip Code

4. Social Security Number _____

5. E-mail address _____

6. Day, Month, & Year of Birth _____ Age _____

7. Current Position _____

8. Medical School/Graduate School _____ Year Graduated _____

9. Residency (if applicable) _____ Year Graduated _____

10. Years in Psychotherapy Practice (if applicable) _____ Current Hours/Week _____

11. List in chronological order your externship(s), internship(s), residency(ies) and fellowships(s):

Name and address of hospital/facility	Service	Date began	Date ended
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EXTERNSHIPS _____

INTERNSHIP _____

RESIDENCIES/
FELLOWSHIPS _____

12. Are you in personal therapy or analysis? Yes _____ No _____

13. Have you previously been in personal therapy or analysis? Yes _____ No _____

14. Letters of recommendation will be requested by the Center from:
a.) The Director of Residency or Internship program from which you graduated.
b.) Two of your psychotherapy supervisors.

Please list the names and addresses of:

DIRECTOR OF RESIDENCY
OR INTERNSHIP TRAINING _____

SUPERVISOR #1 _____

SUPERVISOR #2 _____

15. Have you engaged in research? _____ If so, what subject? _____

Where and when conducted? _____

With whom, or under whose direction? _____

Name and publications arising from it? _____

16. Have you done any medical or psychological teaching? _____ If so, list the subject(s) you taught. _____

Where and when (inclusive dates) _____

17 Licensure: State(s): _____ Year (s) _____

18. a.. Board certification(s) (specify) _____ Year(s) _____

b. If not, are you board eligible? _____

19 a. Have you been in private practice? _____ If so, describe your work _____

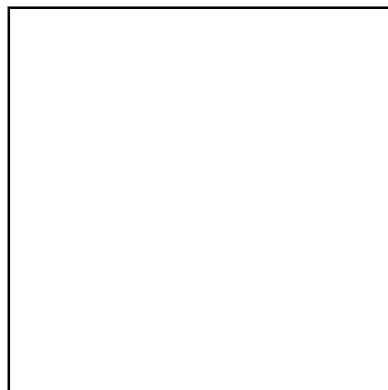
b. Malpractice insurance: Company _____ Amount _____

20 Of what professional societies and organizations are you a member? _____

21. Other professional activities. _____

22 Please describe those aspects of the Child and Adolescent Psychodynamic Psychotherapy Training that would be most suited to your current need for additional training.

This application must be accompanied by proof of current licensure and of malpractice coverage. A copy of the face sheet of your insurance policy should contain the necessary information for proof of malpractice coverage.



In addition to the photograph to be posted on this square, please supply two or more for our records. (Preferred dimensions of photograph, 2"x2")