

**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 *Friends of Columbia Psychoanalytic Center*, 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 \_\_\_\_\_

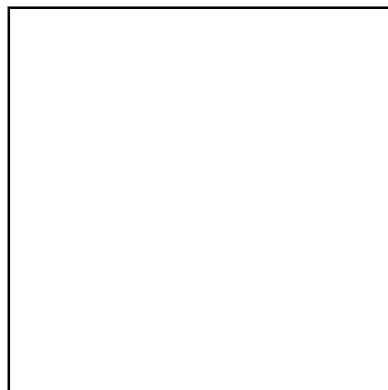
b. Malpractice insurance: Company \_\_\_\_\_ Amount \_\_\_\_\_

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")