

NYU Psychoanalytic Institute

Tel: 212-263-6243 www.psa.med.nyu.edu Fax: 212-263-6417

APPLICATION FOR PSYCHODYNAMIC PSYCHOTHERAPY TRAINING

(rev. 4/26/07)

Adult Program

Child & Adolescent Program

PERSONAL INFORMATION

Name/Degree:

Date of Application:

HOME	Address:			
	City/State/Zip:			
	Telephone:		Fax:	
Email:				

PRIVATE OFFICE	Address:			
	City/State/Zip:			
	Telephone:		Fax:	
Email:				

EMPLOYER	Address:			
	City/State/Zip:			
	Telephone:		Fax:	
Email:				

Place of Birth:	Citizenship:	Sex:
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Date of Birth:	Social Security #:
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CLINICAL PRACTICE EXPERIENCE (if applicable)

It is helpful for us to know the breadth and range of your clinical experience. Please provide a brief summary of patients you have seen.

Pt. Age	Gender	Setting	Duration (mos., yrs.)	Comments

PERSONAL CLINICAL EXPERIENCE PSYCHOTHERAPY or PSYCHOANALYSIS			
Dates	Frequency	Duration	Comments

PERSONAL MEDICAL HISTORY
Have you experienced any significant medical conditions?

CURRICIULUM VITAE

Please attach your Curriculum Vitae to this application, listing your undergraduate and graduate education and training (degrees, dates, institutions), and dissertation subject (if applicable).

REFERENCES - *(Address - please be specific with building #, department, zip code, etc.)*

Clinical Training Director

1.

Address:	
City/State/Zip:	

Telephone:	Fax:
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Email:

Another individual familiar with your current clinical work

2.

Address:	
City/State/Zip:	

Telephone:	Fax:
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Email:

How did you first hear of NYU Psychoanalytic Institute?

DECLARATION OF LEGAL AND ETHICAL STANDING

Have you ever been charged with a criminal offense, ethics violation or a civil complaint of a professional nature? Yes No

Has your license ever been suspended, revoked or limited? Yes No

Have your professional privileges ever been limited or denied, or have you been censured by a professional organization? Yes No

If the answer to any of the above questions is yes, please provide or attach an explanation.

I understand that my application and progress within this program will be subject to assessment by the instructors and supervisors in the program, and I agree to abide by this assessment.

In addition, I understand and agree that consideration of this application by the Institute and my participation in the program, including the awarding of a certificate, is at the sole discretion of the Institute, and under no circumstances will the Institute, its officers, faculty, employees, or members be liable to me by reason of any action or inaction in the relation thereto.

Signature: _____ Date: _____

Please be sure to include the following with your application:

- A copy of your license to practice
- A copy of your curriculum vitae
- A copy of current malpractice insurance (if self-insured)
- A check for \$100 made out to: NYU Psychoanalytic Institute

Mail completed application to:

*NYU Psychoanalytic Institute
NYU School of Medicine, OBV CD 230 * 400 E. 34th Street * New York, NY 10016*