



# THE CHICAGO INSTITUTE FOR PSYCHOANALYSIS

EDUCATION | TREATMENT | SERVICE

**ADULT PSYCHOTHERAPY CLINIC FELLOWSHIP PROGRAM**  
of the  
**INSTITUTE FOR PSYCHOANALYSIS**  
122 SOUTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60603  
(312)922-7474

**APPLICATION FOR ENROLLMENT**  
(please print or type)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Home Telephone with Area Code \_\_\_\_\_

E-mail Address \_\_\_\_\_

Professional Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Work Telephone with Area Code \_\_\_\_\_

Please indicate preferred mailing address: Home \_\_\_\_\_ Office \_\_\_\_\_

Citizenship \_\_\_\_\_

Professional Licensure (type, state, date) \_\_\_\_\_

Professional Liability Insurance (name of company, policy number, effective dates) \_\_\_\_\_

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FILL IN AS APPLICABLE:

ACADEMIC TRAINING

|               | Institution | Dates Attended | Degree |
|---------------|-------------|----------------|--------|
| Undergraduate | _____       | _____          | _____  |
| Graduate      | _____       | _____          | _____  |
| Postgraduate  | _____       | _____          | _____  |

CLINICAL TRAINING

|                                       | Institution | Name of Program | Position | Dates |
|---------------------------------------|-------------|-----------------|----------|-------|
| Internship                            | _____       | _____           | _____    | _____ |
| Residency                             | _____       | _____           | _____    | _____ |
| Fellowship                            | _____       | _____           | _____    | _____ |
| Other Professional Training (specify) | _____       |                 |          |       |

BOARD CERTIFICATION (certifying body, date) \_\_\_\_\_  
\_\_\_\_\_

PRIVATE PRACTICE

| Type of Practice | Location | Hours/Week | Dates |
|------------------|----------|------------|-------|
| _____            | _____    | _____      | _____ |
| _____            | _____    | _____      | _____ |

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OTHER PROFESSIONAL WORK EXPERIENCE (beginning with most recent)

Place of Employment \_\_\_\_\_  
Dates \_\_\_\_\_ Hours/Week \_\_\_\_\_  
Position \_\_\_\_\_  
Nature of Work \_\_\_\_\_

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Place of Employment \_\_\_\_\_  
Dates \_\_\_\_\_ Hours/Week \_\_\_\_\_  
Position \_\_\_\_\_  
Nature of Work \_\_\_\_\_

How many psychotherapy cases are you seeing currently? \_\_\_\_\_

MEMBERSHIP IN PROFESSIONAL SOCIETIES

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PROFESSIONAL ACTIVITIES (teaching, research, publications, community work – if lengthy, you may substitute your CV, if you wish)

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PERSONAL PSYCHOLOGICAL TREATMENT

List any current or past psychotherapy or psychoanalysis, with dates and frequency. Names optional.

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ETHICS

Have you ever been the subject of an ethical review? If so, when and what was the outcome?

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Signature \_\_\_\_\_ Date \_\_\_\_\_

TRANSCRIPT, REFERENCES AND PERSONAL STATEMENT

1. Please arrange to have **two references** send letters of reference on your behalf to us. **One should be either the training director at your most recent place of academic or clinical training, or the person to whom you currently report; the other should be one who knows your current work with patients.** (If your training was not recent, and if you have not recently had a person to whom you report, you may substitute a second person who knows your work with patients.) Please send to each a copy of the Request for Letter of Reference Form (copies enclosed).
2. Please arrange that the transcript from your most recent training program be sent, by that program, to the Director of Education Administration, Alison Chandler.
3. Please also attach a brief personal statement, no longer than one page explaining your interest in this program.
4. **The application fee is \$50.00 (check payable to Institute for Psychoanalysis), and is non-refundable. Please send completed application form, enclosures and check to:**

Alison Chandler, Director of Education Administration  
 Institute for Psychoanalysis  
 122 South Michigan Avenue, Suite 1300  
 Chicago, Illinois 60603