



**APPLICATION FOR ENROLLMENT**

<b>NAME:</b>		<b>DATE OF BIRTH:</b>
<b>HOME ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>HOME/CELL PHONE NUMBER:</b>		<b>EMAIL:</b>

<b>PROFESSIONAL ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>WORK PHONE:</b>		
<b>PLEASE INDICATE PREFERRED MAILING ADDRESS:</b> <input type="checkbox"/> HOME <input type="checkbox"/> WORK		

<b>COUNTRY OF CITIZENSHIP:</b>	
<b>GENDER:</b>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<b>RACE/ETHNICITY:</b>	
<input type="checkbox"/> WHITE/CAUCASIAN	<input type="checkbox"/> NATIVE AMERICAN OR ALASKA NATIVE
<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER
<input type="checkbox"/> ASIAN	<input type="checkbox"/> TWO OR MORE RACES
<input type="checkbox"/> HISPANIC OR LATINO	

**THE FOLLOWING INFORMATION IS OPTIONAL:**

<b>MARITAL STATUS</b>		
<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED	
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> PARTNERED	
<input type="checkbox"/> SEPARATED	<input type="checkbox"/> SINGLE	
<b>CHILDREN:</b>		
NAME:	AGE:	GENDER:
NAME:	AGE:	GENDER:
NAME:	AGE:	GENDER:
NAME:	AGE:	GENDER:
NAME:	AGE:	GENDER:

**ACADEMIC TRAINING (FILL IN AS APPLICABLE):**

<b>UNDERGRADUATE INSTITUTION:</b>	
<b>DATES ATTENDED:</b>	<b>DEGREE:</b>
<b>GRADUATE INSTITUTION:</b>	
<b>DATES ATTENDED:</b>	<b>DEGREE:</b>
<b>POST-GRADUATE INSTITUTION:</b>	
<b>DATES ATTENDED:</b>	<b>DEGREE:</b>

**TRAINING WITH ADOLESCENTS AND CHILDREN**

(List all work experience, especially work with emotionally disturbed children and adolescents. Include practice and work agencies):

<b>AGENCY OR OTHER SETTING:</b>	<b>HOURS/WEEK:</b>	
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>NAME OF ADMINISTRATOR:</b>	<b>TITLE:</b>	
<b>YOUR POSITION:</b>		
<b>DATES FROM:</b>	<b>DATES TO:</b>	
<b>NAME OF CONSULTANT OR SUPERVISOR:</b>		
<b>NATURE OF WORK:</b>		

<b>AGENCY OR OTHER SETTING:</b>	<b>HOURS/WEEK:</b>	
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>NAME OF ADMINISTRATOR:</b>	<b>TITLE:</b>	
<b>YOUR POSITION:</b>		
<b>DATES FROM:</b>	<b>DATES TO:</b>	
<b>NAME OF CONSULTANT OR SUPERVISOR:</b>		
<b>NATURE OF WORK:</b>		

<b>AGENCY OR OTHER SETTING:</b>	<b>HOURS/WEEK:</b>	
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>NAME OF ADMINISTRATOR:</b>	<b>TITLE:</b>	
<b>YOUR POSITION:</b>		
<b>DATES FROM:</b>	<b>DATES TO:</b>	
<b>NAME OF CONSULTANT OR SUPERVISOR:</b>		
<b>NATURE OF WORK:</b>		

<b>AGENCY OR OTHER SETTING:</b>	<b>HOURS/WEEK:</b>	
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>NAME OF ADMINISTRATOR:</b>	<b>TITLE:</b>	
<b>YOUR POSITION:</b>		
<b>DATES FROM:</b>	<b>DATES TO:</b>	
<b>NAME OF CONSULTANT OR SUPERVISOR:</b>		
<b>NATURE OF WORK:</b>		

**PRIVATE PRACTICE EXPERIENCE:**

<b>LIST LICENSURE AND/OR CERTIFICATION FOR PRACTICE:</b>	
<b>DATE:</b>	
<b>TYPE OF PRACTICE:</b>	<b>PHONE:</b>
<b>MALPRACTICE INSURANCE COMPANY (INCLUDE A COPY):</b>	
<b>POLICY #:</b>	
<b>EFFECTIVE FROM:</b>	<b>TO:</b>

**LIST OTHER PROFESSIONAL EXPERIENCE: (Teaching, Student Supervision, Consultation to Social Agencies, etc.)**  
**Indicate agency or school affiliation, if any, approximate amount of time, dates, etc.)**


**GENERAL INFORMATION: (Describe any physical limitations that need special accommodations)**


**PERSONAL ANALYSIS/PSYCHOTHERAPY – PAST, PRESENT, OR PLANNED**  
**(For administrative purposes only. No information will be requested or disclosed):**

<b>NAME OF ANALYST/PSYCHOTHERAPIST:</b>	
<b>FREQUENCY:</b>	<b>LENGTH OF TIME:</b>
<b>DATES FROM:</b>	<b>TO:</b>
<b>NAME OF ANALYST/PSYCHOTHERAPIST:</b>	
<b>FREQUENCY:</b>	<b>LENGTH OF TIME:</b>
<b>DATES FROM:</b>	<b>TO:</b>
<b>NAME OF ANALYST/PSYCHOTHERAPIST:</b>	
<b>FREQUENCY:</b>	<b>LENGTH OF TIME:</b>
<b>DATES FROM:</b>	<b>TO:</b>

**HOW DID YOU HEAR ABOUT US?**

- INTERNET SEARCH/INSTITUTE WEBSITE
- PRIOR OR CURRENT STUDENT
- CONTINUING EDUCATION EVENT
- OPEN HOUSE
- COLLEAGUE OR REFERRAL
- RADIO ADVERTISEMENT
- EMAIL ADVERTISEMENT

<b>SIGNATURE:</b>	<b>APPLICATION DATE:</b>
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**PLEASE SUBMIT COMPLETED APPLICATION AND THE FOLLOWING ADDITIONAL MATERIALS TO:**

**Alison Chandler, Education Programs Coordinator  
122 South Michigan Ave, Ste. 1300  
Chicago, IL 60603  
achandler@chicagoanalysis.org**

- \$100 Application Fee (Non-Refundable) – Checks Made Payable to “Institute for Psychoanalysis”**
- Academic and Professional Transcripts**
- Copies of Professional License and Malpractice Insurance Certificate**
- (3) Letters of reference (Please see reference form on website - CAPPT section)**

*The Chicago Institute for Psychoanalysis admits students of any race, color, and national or ethnic origin.*