



APPLICATION FOR ENROLLMENT

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

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

COUNTRY OF CITIZENSHIP:	
GENDER:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE/ETHNICITY:	
<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:

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

ACADEMIC TRAINING (FILL IN AS APPLICABLE):

UNDERGRADUATE INSTITUTION:	
DATES ATTENDED:	DEGREE:
GRADUATE INSTITUTION:	
DATES ATTENDED:	DEGREE:
POST-GRADUATE INSTITUTION:	
DATES ATTENDED:	DEGREE:

TRAINING WITH ADOLESCENTS AND CHILDREN

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

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

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

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

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

PRIVATE PRACTICE EXPERIENCE:

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

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):

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

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

SIGNATURE:	APPLICATION DATE:
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PLEASE SUBMIT COMPLETED APPLICATION AND THE FOLLOWING ADDITIONAL MATERIALS TO:

**Alison Chandler, Director of Education Administration
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.