



THE CHICAGO INSTITUTE FOR PSYCHOANALYSIS

EDUCATION | TREATMENT | SERVICE

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

APPLICATION FOR ENROLLMENT
(please print or type)

I am also applying for the Adult Psychotherapy Clinic Fellowship Program

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 _____ Social Security Number _____

Professional Licensure (type, state, date) _____

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

Upon acceptance, applicant must send copies of licensure and certificate of liability insurance to the Registrar annually during training.)

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER PROFESSIONAL WORK EXPERIENCE (beginning with most recent)

Place of Employment _____
Dates _____ Hours/Week _____
Position _____
Nature of Work _____

Place of Employment _____
Dates _____ Hours/Week _____
Position _____
Nature of Work _____

Place of Employment _____
Dates _____ Hours/Week _____
Position _____
Nature of Work _____

Place of Employment _____
Dates _____ Hours/Week _____
Position _____
Nature of Work _____

How many psychotherapy cases are you seeing currently? _____

ACADEMIC AND HOSPITAL APPOINTMENTS

Institution	Position	Dates

MEMBERSHIP IN PROFESSIONAL SOCIETIES

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

Signature _____ Date _____

REFERENCES

Please arrange to have two individuals 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).

Please arrange that the transcript from your most recent training program be sent, by that program, to the Education Programs Coordinator, Alison Chandler.

**If also applying to the fellowship, Please attach a brief personal statement, no longer than one page explaining your interest in Clinic Fellowship.

The application fee is \$100.00 (check payable to Institute for Psychoanalysis), and is non-refundable. Please send completed application form, enclosures and check to:

Alison Chandler
 Education Programs Coordinator
 Institute for Psychoanalysis
 122 South Michigan Avenue, Suite 1300
 Chicago, Illinois 60603