The Institute for Psychoanalysis
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CHILD AND ADOLESCENT PSYCHOANALYTIC PSYCHOTHERAPY TRAINING PROGRAM
(CAPPT)
APPLICATION FOR ENROLLMENT

(Please print or type answers)

Name _____

Home Address_____City _____State_____ Zipcode_____

Phone_____ Cell_____Fax_____Email_____

Private Practice: Name_____

Address_____City _____State_____ Zipcode_____

Phone_____ Cell_____Fax_____Email_____

Name of Agency _____

Present Position _____

Address_____City _____State_____ Zipcode_____

Phone_____ Cell_____Fax_____Email_____

Place and Date of Birth_____

You are not required to answer the question regarding marital status
Please check the appropriate box if you choose to answer

Marital Status	
Married	
Divorced	
Separated	
Widowed	
Single	

Children:

Names	Age	Gender

ACADEMIC TRAINING (List most recent first)

Undergraduate, Graduate and Post graduate

Name of Institution:	From:	To:	Degree and Date

Training with Adolescents and Children

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

(List most recent experience first)

1. Agency or other setting _____Hours per Week_____

Address_____City_____State_____Zipcode_____

Name of Administrator_____Title_____

Your Position_____Dates: From_____To _____

Name of Consultant and/or Supervisor _____

Nature of Work_____

2. Agency or other setting _____Hours per Week_____

Name of Administrator _____Title_____

Address_____City_____State_____Zipcode_____

_

Name of Administrator_____Title_____

Your Position_____Dates: From_____To _____

Name of Consultant and/or Supervisor _____

Nature of Work_____

3. Agency or other setting _____Hours per Week_____

Name of Administrator _____

Your Position _____Dates: From_____To _____

Name of Consultant and/or Supervisor_____

Nature of Work_____

_____

Agency or other setting _____Hours per Week____

Address_____City_____State_____Zipcode_____

Name of Administrator _____

Your Position _____Dates: From_____To _____

Name of Consultant and/or Supervisor _____

Nature of Work_____

_____

PRIVATE PRACTICE EXPERIENCE

1. List Licensure and/or Certification for Practice:

_____ Date: _____

_____ Date: _____

Type of Practice _____Phone _____

2. Malpractice Insurance:

   Name of Company_____ Policy Number_____

   Effective Dates: From:_____ To_____

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, PLANNED

(Administrative purposes only, no information will be requested or disclosed)

Name of Analyst/Psychotherapist_____
Address_____ City_____State___Zipcode_____
Frequency _____ Length of Time _____Dates: From_____To _____

PUBLICATIONS (Please list and submit reprints)_____

_____

_____

_____

_____

PROFESSIONAL AFFILIATIONS

Please list 3 references, two of which are/were a supervisor. Include current addresses and phone numbers so that we may ask for reference letters on your behalf to the Child and Adolescent Psychoanalytic Psychotherapy Training Program Office.

Name	Address	City State	Zip	Phone	E Mail

Please send or have sent to the Child and Adolescent Psychoanalytic Psychotherapy Training Program Office at : The Institute of Psychoanalysis
122 S. Michigan Av. Suite 1300,
Chicago, Il 60603

1. A transcript of your undergraduate and graduate records
2. A $100 application fee

DATE_____SIGNATURE_____