PLEASE NOTE APPLICATION DEADLINE IS April 1st IN EVEN-NUMBERED YEARS

APPLICATION FOR ADMISSION

Denver Institute for Psychoanalysis

2-YEAR ADULT
PSYCHODYNAMIC PSYCHOTHERAPY PROGRAM
(PTP)

Mailing Address:
The Denver Institute for Psychoanalysis
Mail Stop F546
13001 E. 17th Place, Room E2327
Aurora, CO 80045
(303) 724-2666
Fax: (303) 724-2668

Email: institute@denverpsychoanalytic.org
Website: www.denverpsychoanalytic.org

Affiliates of the Department of Psychiatry
University of Colorado Denver, School of Medicine

(For Office Use)

Date Appl. Received: _____

Appl. Fee Received: _____

Ref. Received: _____

_____

_____

License Received: _____

Malpractice Ins.: _____

APPLICATION – PLEASE TYPE OR PRINT
PSYCHODYNAMIC PSYCHOTHERAPY TRAINING PROGRAM
(PTP)

NAME: _____ DEGREE/TITLE:_____

Birthdate (optional) _____ Marital status (optional) Married

ADDRESS (**Check Preferred Mailing Address**)

☐ OFFICE: _____

_____

TELEPHONE: _____

☐ HOME: _____

_____

TELEPHONE: _____

EMAIL ADDRESS _____

FAX _____ Choose one: Office Fax

PRESENT POSITION: _____

_____

CELL PHONE: PRACTICE WEBSITE:

SPECIALTY LICENSURE (State and Date):

_____

_____

SPECIALTY BOARD CERTIFICATION (Date):

_____

_____

PERSONAL THERAPY:

Psychotherapy (Dates, Therapists' Names, City/State):

_____
_____
_____
_____
_____
_____

Psychoanalysis (Dates, Number of times per week, Analyst's Names, City/State):

_____
_____
_____
_____
_____
_____

CURRICULUM VITAE

A. Academic Training (Undergraduate, Graduate, Post-Graduate, Medical)

SCHOOL	DEGREE	FIELD	DATES
_____			FROM_____TO_____
_____			FROM_____TO_____
_____			FROM_____TO_____
_____			FROM_____TO_____
_____			FROM_____TO_____

B. FIELD PLACEMENT, CLINICAL INTERNSHIP, PRE AND POST-DOCTORAL FELLOWSHIP (Use a separate sheet if more space is needed.)

1) Dates, Names, City/State:

2) Type of Settings (hospital, clinic, private practice, etc.):

3) Description of Professional Responsibilities:

4) Names and Professional Degrees of Supervisors:

C. CONTINUING EDUCATIONAL CLINICAL EXPERIENCE AND TRAINING: (Use a separate sheet if necessary. If this information is available in your vitae, there is no need to repeat it here.)

1) Continuing Education Courses and Instructors' Names:

2) Supervision: (Names, Dates, Frequency)

D. CLINICAL TEACHING EXPERIENCE:

1) Courses, Seminars, Lectures, etc.:

2) Supervision you have given:

E. PUBLICATIONS AND WRITINGS:

F. CURRENT PROFESSIONAL ACTIVITIES AND AREAS OF INTEREST:

1) Please describe your current clinical practice:

Please indicate the average number of patients seen per week in each of past 3 years spent doing individual psychodynamic psychotherapy:

	Year	Once Per Week	Twice Per Week	Three Times Per Week
ADULT	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
ADOLESCENT				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
CHILD				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

2) Current Academic or Other Positions and Responsibilities:

3) Research Training and Experience, Past & Present

G. PLEASE EXPLAIN YOUR INTEREST IN THE PSYCHODYNAMIC PSYCHOTHERAPY PROGRAM. INCLUDE YOUR LEARNING OBJECTIVES.

MALPRACTICE AND ETHICS INFORMATION

1) Have your clinical privileges ever been suspended or withdrawn?

☐ YES ☐ NO (If yes, please explain on separate page)

2) Have any malpractice claims ever been made against you, including claims currently pending, Or settled, and that have resulted in judgments against you?

☐ YES ☐ NO (If yes, please explain on separate page)

3) Has your professional license ever been revoked, suspended, or had limitations put on it?

☐ YES ☐ NO (If yes, please explain on separate page)

4) Within the past 5 years, have you ever resigned, been suspended or excluded from the staff of any hospital or professional organization because of problems related to the loss/restriction of privileges?

☐ YES ☐ NO (If yes, please explain on separate page)

5) Has your DEA license ever been suspended or revoked?

☐ YES ☐ NO (If yes, please explain on separate page)

6) Have you ever been denied professional liability insurance?

☐ YES ☐ NO (If yes, please explain on separate page)

_____ _____

Signature Date

REFERENCES: (Please give names and addresses of three people who know your clinical work with patients, **whom you have asked** to send us a reference letter.)

- _____

_____

- _____

_____

- _____

_____

How did you hear about the PTP Program at the Denver Institute for Psychoanalysis?

_____

ATTESTATION STATEMENTS:

I attest that this information provided by me is true and accurate	Select One
I understand my application could be denied if I have not been truthful	Select One
I understand I am obligated to update the Denver Institute for Psychoanalysis if my situation changes	Select One

Signature: _____

PLEASE ATTACH:

1) $100 application fee for application processing.
   Make check payable to:
   ***The Denver Institute for Psychoanalysis*.**

2) Xerox copy of your current license and malpractice insurance.

SEND COMPLETED APPLICATION TO:

The Denver Institute for Psychoanalysis
Mail Stop F546
13001 E. 17th Place
Aurora, CO 80045