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) _____

ADDRESS (**Check Preferred Mailing Address**)

OFFICE: _____

_____

TELEPHONE: _____

HOME: _____

_____

TELEPHONE: _____

EMAIL ADDRESS _____

FAX _____ Circle one: Home fax – Office fax

PRESENT POSITION: _____

_____

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.)

- _____

_____

- _____

_____

- _____

_____

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 all to -

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