



**NATIONAL INSTITUTE for the PSYCHOTHERAPIES
TRAINING INSTITUTE**

250 West 57th Street, Suite 501 New York, NY 10019
Phone: (212) 582-1566 Fax: (212) 586-1272

**Training Program In Psychoanalysis and
Comprehensive Psychotherapy
THREE YEAR CHILD & ADOLESCENT PROGRAM APPLICATION**

PLEASE PRINT OR TYPE ALL INFORMATION

APPLICATION FEE: \$50

NAME: _____ SOCIAL SECURITY # : _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE ADDRESS: _____

HOME TELEPHONE: () _____ OFFICE TELEPHONE: () _____

EMAIL ADDRESS: (Please print) _____

DATE OF BIRTH: ____ / ____ / ____ CITY OF BIRTH: _____ SEX: _____

PROFESSIONAL TITLE: _____
(e.g., Mental Health Nurse, Psychiatrist, Psychologist, Social Worker, etc.)

| EDUCATION: INSTITUTION | DATES | MAJOR | DEGREE |
|---------------------------|-------|-------|--------|
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PERSONAL PSYCHOTHERAPY: THERAPIST
CURRENT:

NAME _____ ADDRESS _____

ORIENTATION _____ DATES _____ # OF HOURS _____

PLEASE GIVE THE NAME OF THE POSTGRADUATE TRAINING INSTITUTE WHERE YOUR PRESENT
THERAPIST'S TRAINING WAS COMPLETED:

POSTGRADUATE TRAINING INSTITUTE _____ DATE OF COMPLETION _____

Please Note: In order for your present therapist to be acceptable as your NIP training therapist, he/she must be a graduate of a recognized postgraduate training institute with a minimum of five years postgraduate experience.

PAST:

NAME **ADDRESS**

ORIENTATION **DATES** **# OF HOURS**

PSYCHOTHERAPY SUPERVISION:

SUPERVISOR **ADDRESS** **#of HOURS SUPERVISION** **TYPE of THERAPY** **DATES**

PAID WORK EXPERIENCE TO DATE:

COMPANY, INSTITUTE, IMMEDIATE SCHOOL, PRIVATE AGENCY **DATES** **TYPE of WORK PERFORMED** **HOURS/ WORKED** **SUPERVISOR**

NATURE OF PRESENT PSYCHOTHERAPEUTIC WORK: _____

TYPES OF THERAPY USED: _____

HOURS PER WEEK ENGAGED IN PSYCHOTHERAPY:

? PRIVATELY _____

? IN INSTITUTIONS or AGENCIES _____

PRESENT SUPERVISOR(S): _____

AGES AND TYPES OF PATIENTS: _____

PUBLICATIONS: _____

TITLE OF THESIS OR DISSERTATION: _____

RESEARCH ENGAGED IN: _____

RESEARCH INTERESTS: _____

PROFESSIONAL LICENSES AND/OR CERTIFICATES: _____

PROFESSIONAL AFFILIATIONS: _____

HONORS, AWARDS, SCHOLARSHIPS: _____

OTHER PERTINENT INFORMATION YOU WISH US TO KNOW:

NAMES AND ADDRESSES OF THREE REFERENCES: TWO EMPLOYERS AND A CURRENT SUPERVISOR. PLEASE HAVE THESE LETTERS OF REFERENCE FORWARDED TO NIP.

NAME

ADDRESS

HOW DID YOU LEARN ABOUT NIP'S CHILD & ADOLESCENT TRAINING PROGRAM?

DID YOU ATTEND THE OPEN HOUSE? YES: ___ NO: ___

SIGNATURE

DATE

Please include the following with your completed application:

? Transcripts of all undergraduate and graduate work

? A copy of your current malpractice insurance certificate (In most cases insurance may be obtained from the American Professional Agency, 95 Broadway, Amityville, NY 11701, 631-691-6400.)

? A copy of your NYS License

? Your current therapist's vita for approval (Your therapist must be licensed in his/her field and be a graduate of a recognized post graduate training program with at least five years of post graduate experience.)

? A nonrefundable application fee of \$50.00