



application fee: \$25.00
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Friends of the Columbia Psychoanalytic Center

COLUMBIA UNIVERSITY DEPARTMENT OF PSYCHIATRY
Parent-Infant Psychotherapy Training Program

*of the Center for Psychoanalytic Training and Research
Child Psychoanalysis Division*

*1051 Riverside Drive, New York, NY 10032
212-927-5000*

Application for Admission

Date:

Name (Last, First, M.I., Degree):

Present Mailing Address (Number & Street, City, State, Zip):

Present Telephone Numbers (Area Code & Number):

Day:

Evening:

Present Fax Number (Area Code & Number):

Present E-Mail Address:

Permanent Home Address (Number & Street, City, State, Zip):

Permanent Home Telephone Number (Area Code & Number):

Place and Date of Birth:



Is English your native language?

What other languages do you speak?

Social Security Number:

Current Professional Position:

Education (Include Institution, Degree and Year Obtained for Each):

College:

Graduate School:

Medical School:

Psychoanalytic Institute:

List other training and clinical experiences in child or infant work:

List in chronological order your extership(s), internship(s), residency(ies), and fellowship(s)



(Include name & address of hospital/facility, service, date begun & ended for each)

Externships:

Internships:

Residencies:

Fellowships:

Have you engaged in research?

If so, what subject?

Where and when?

With whom or under whose direction?

List here your publications including dissertation:

Have you done any medical or psychological teaching? If so, list the subjects, institutions, and



inclusive dates:

Licensure (Include States and Years):

Board Certification(s) (Include Specialty and Years); If not Board Certified, are you Board Eligible?

Have you been or are you currently in private practice?

If so, roughly what percentage of your practice is devoted to each of the following?

Individual Child Psychotherapy

Individual Child Psychoanalysis

Family Therapy

Group Therapy

Individual Adult Psychotherapy

Individual Adult Psychoanalysis

Couples Therapy

Other (please describe)

Malpractice Insurance (List Company):

Amount of Malpractice Coverage:

Of what professional societies and/or organizations are you a member?



List other professional activities:

Professional references (Please have two letters of recommendation from professional colleagues who directly know your clinical work sent to the Parent-Infant Program— Columbia University Center for Psychoanalytic Training and Research— 1051 Riverside Drive, Box 63, New York, NY 10032. Please write their names, addresses and telephone numbers below)

How did you learn of this program?



Please, describe in 1 or 2 paragraphs the reasons for your interest in this program, and your long-term goals.

Please type or write legibly in ink.

Attach your check or money order for \$25 payable to Friends of the Columbia Psychoanalytic Center. This fee covers part of the cost of processing your application and therefore is not refundable.

Mail two copies of this form plus Xeroxed copies of your current license and malpractice coverage to:

Ms. Joan Jackson
Center for Psychoanalytic Training and Research
Department of Psychiatry
1051 Riverside Drive, Box 63, New York, NY 10032.

For further information call The Parent-Infant Program at 212-560-2444.