

# COLUMBIA UNIVERSITY

**The Center for Psychoanalytic Training and Research  
1051 Riverside Drive  
New York, New York 10032**

## *Application for Admission*

Instructions: 1 Please write legibly in ink. 2. Attach your check or money order for \$150 payable to *Columbia University*, where specified below: this fee covers part of the cost of processing your application and therefore is not refundable. 4. Mail to the *Center for Psychoanalytic Training and Research, 1051 Riverside Drive, Box 63, New York, N.Y. 10032.*

Date \_\_\_\_\_

1. Name \_\_\_\_\_ Degree \_\_\_\_\_  
Last First Middle

2. Present Mailing/Office Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
City State Zip Code

3. Permanent Home Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
City State Zip Code

4. E-mail address \_\_\_\_\_

5. Day, Month, & Year of Birth \_\_\_\_\_ Age \_\_\_\_\_

6. Nationality \_\_\_\_\_ Place of Birth \_\_\_\_\_

Citizenship \_\_\_\_\_ If not U.S., green card or visa status \_\_\_\_\_

Primary Language \_\_\_\_\_ Other languages spoken \_\_\_\_\_

Previous Occupation (if any) \_\_\_\_\_

7. Domestic Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Living with significant other \_\_\_\_\_

8. # of children \_\_\_\_\_

9. Social Security Number \_\_\_\_\_

10. Current Position \_\_\_\_\_

11. List in chronological order the schools you have attended?

	<b>Name and Address Of Institution</b>	<b>Date of Attendance</b>	<b>Degree Awarded</b>	<b>Year</b>
COLLEGE(S)	_____			
	_____			
MEDICAL SCHOOL(S)/	_____			
GRADUATE SCHOOL(S) (Specify field)	_____			
	_____			

12. List in chronological order your internship(s), residency(ies), and fellowship(s):

A. M.D.'s  
Psychiatric Residency Program: \_\_\_\_\_  
Year Completed (or to be completed): \_\_\_\_\_  
Internship Program: \_\_\_\_\_  
Year Completed (or to be completed): \_\_\_\_\_  
Fellowship Program (if any): \_\_\_\_\_  
Year completed (or to be completed) \_\_\_\_\_

B. Ph.D's  
Internship Location: \_\_\_\_\_  
Year Completed (or to be completed): \_\_\_\_\_  
Fellowship Program (if any): \_\_\_\_\_  
Year completed (or to be completed) \_\_\_\_\_

13. Have you engaged in research? \_\_\_\_\_ If so, in what subject? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where and when conducted? \_\_\_\_\_

With whom, and under whose direction? \_\_\_\_\_

Names and publications arising from it? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Have you done any teaching? \_\_\_\_\_ If so, list the subject(s) you taught \_\_\_\_\_

\_\_\_\_\_

Where and when (inclusive dates) \_\_\_\_\_

\_\_\_\_\_

15. Licensure: State(s) \_\_\_\_\_ Year \_\_\_\_\_

16. A. Board Certification(s): Specify \_\_\_\_\_ Years(s) \_\_\_\_\_

B. If not, are you Board eligible? \_\_\_\_\_

17. A. Have you been in private practice? \_\_\_\_\_ If so, describe your work \_\_\_\_\_

\_\_\_\_\_

B. Malpractice Insurance: Company \_\_\_\_\_ Amount \_\_\_\_\_

18. Of what professional societies or organizations are you a member? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

19. Other professional or educational activities \_\_\_\_\_

\_\_\_\_\_

20. Are you currently in psychotherapy? \_\_\_\_\_ If yes, length to date: \_\_\_\_\_

Name of therapist: \_\_\_\_\_

Are you currently in psychoanalysis? \_\_\_\_\_ If yes, length to date: \_\_\_\_\_

Name of analyst: \_\_\_\_\_

Past Psychotherapy Treatment History:

Therapy \_\_\_\_\_ Analysis \_\_\_\_\_ Length \_\_\_\_\_ Frequency \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_

Name of Therapist or Analyst \_\_\_\_\_

Therapy \_\_\_\_\_ Analysis \_\_\_\_\_ Length \_\_\_\_\_ Frequency \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_

Name of Therapist or Analyst \_\_\_\_\_

Therapy \_\_\_\_\_ Analysis \_\_\_\_\_ Length \_\_\_\_\_ Frequency \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_

Name of Therapist or Analyst \_\_\_\_\_

21. Are you currently applying to any other psychoanalytic institutes? \_\_\_\_\_ If so, please give details below.

NAME AND ADDRESS  
OF INSTITUTION

DATE  
APPLICATION

ACTION TAKEN  
ON APPLICATION

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Have you previously applied for psychoanalytic training? \_\_\_\_\_

If so, please give details below including action taken. \_\_\_\_\_

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22. Professional references (give name and address of each).

**For M.D.'s**

A. Medical School \_\_\_\_\_

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B Internship (one) \_\_\_\_\_

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C. Residency -must be Director of Residency Training

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**For Ph.D's**

A. Graduate School \_\_\_\_\_

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B. Internship -must be Director of Program

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**D. For Both M.D.'s and Ph.D.'s**

Three others: e.g.,  
supervisor, instructor  
including someone  
familiar with your  
recent clinical work)

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

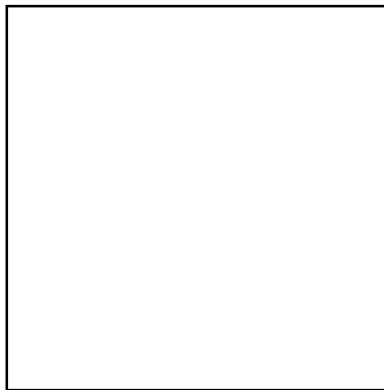
\_\_\_\_\_

**E. Fellowship (if applicable)**

\_\_\_\_\_

\_\_\_\_\_

If you can give additional information that would be pertinent to your request for admission, please write it on a separate sheet and attach to this form.



**In addition to the photograph to be  
pasted on this square, please supply  
two more for our records. (Preferred  
dimensions of photograph, 2" x 2")**

**This application must be accompanied by proof of current licensure and of malpractice coverage. A copy of the face sheet of your insurance policy should contain the necessary information for proof of malpractice coverage.**

