APPLICATION FOR ADMISSION

(Application deadline: January 15th of even-numbered years)

Denver Institute for Psychoanalysis

GENERAL APPLICATION FOR ALL ANALYTIC PROGRAMS:

ADULT PSYCHOANALYTIC
OR
CHILD/ADOLESCENT PSYCHOANALYTIC
OR
COMBINED ADULT & CHILD/ADOLESCENT PSYCHOANALYTIC

An Approved provider of psychoanalytic education by the American Psychoanalytic Association (APsaA)

Affiliates of:

- the American Association for Psychoanalytic Education
- the Department of Psychiatry University of Colorado Denver, School of Medicine

Mailing Address:
THE DENVER INSTITUTE FOR PSYCHOANALYSIS
Mail Stop F546
1890 N. Revere Court, Room 4118
Aurora, CO 80045
(303) 724-2666
Fax: (303) 724-2668
email: institute@denverpsychoanalytic.org
website: www.DenverInstituteForPsychoanalysis.org

OFFICE USE ONLY

Date Appl. Received _____ Appl. Fee Received_____
Transcript Received _____ License Received _____ Malpractice Insurance Received _____
Reference 1 Received _____ Reference 2 Received _____ Reference 3 Received _____

Which program are you applying to? ☐ adult ☐ child & adolescent ☐ both programs

---

Name in full _____ **Credential(s)** _____

Birthdate (optional) _____ **Marital Status (Optional)** _____

Address: Preferred mailing address: ☐ office ☐ home

- **Office:** _____ **Telephone** _____
  _____ **Fax** _____
- **Home:** _____ **Telephone** _____
  _____ **Email** _____

Cell Phone: _____ **Practice Website:** _____

Present position _____ **Prefered Pronouns:** Select from list

Citizenship _____ **If non-citizen, what is your present status and future plans regarding permanent residence and citizenship?**

Medical or Specialty Licensure (State & Date). Please submit a copy of your license

_____

Specialty Board Certification (Date). Please provide a copy of your certification

_____

Malpractice Insurance (Name of company and expiration date. Please provide a copy of the page which indicates type and extent of coverage.)

PERSONAL THERAPY:

Psychotherapy: (Dates, therapists' names and addresses)

Psychoanalysis: (Dates, total # of hours, analysts' names and addresses)
Note: We will not be contacting your analyst directly, but need this information for our records.

ACADEMIC TRAINING (Undergraduate, graduate, post-graduate, medical)

School	**Degree/Field**	**Dates**
		From_____ to _____
		From_____ to _____
		From_____ to _____
		From_____ to _____

INTERNSHIP, RESIDENCIES, POST GRADUATE & CLINICAL TRAINING : Include Fellowships and clinical settings. Please provide names, addresses and dates.
Use additional sheet if necessary

EXPERIENCE: Medical and non-medical in current field of interest. Give dates and locations. Use additional sheet if necessary

CONTINUING EDUCATION CLINICAL EXPERIENCE AND TRAINING: Give courses, supervision and clinical placement. Use additional sheet if necessary.

CLINICAL TEACHING EXPERIENCE: Settings, position, duties, courses, supervision. Use additional sheet if necessary.

CURRENT FIELD OF INTEREST: Teaching, private practice, etc., date and locations. Use additional sheet if necessary.

PUBLICATIONS AND WRITINGS: Please submit copies if possible – up to 5 articles.

RESEARCH INTEREST: Training and experience, past, present, future). Use additional sheet if necessary

In addition, please enclose the following supplementary information:

1) Curriculum Vitae
2) Resume of your scientific background, including major areas of work and research
3) At least a two-page summary of a case* you've worked with in depth, describing the process of treatment, problems as they occurred and were dealt with, and transference and counter-transference issues. Please write this up as though you were telling a friend about an interesting clinical case.

(*Please note: If you are applying for adult training, this should be an adult patient. If you are applying for child/adolescent training, it should be a child or adolescent patient. If you are applying for the combined adult & child/adolescent training, two case write-ups are required, one adult case and one child or adolescent case.)

PATIENT INFORMATION: (Please list the average number of patients seen per week in each of the past 3 years spent in doing psychodynamic psychotherapy)

	Year	Dx/Problem	Once/wk.	Twice/wk.	3x/wk.
Adult					
Adolescent					
Child					

PERSONAL AUTOBIOGRAPHY: Include relevant factors that show why you might have developed an interest in psychoanalysis and relevant factors from your personal life which were part of the evolution of your interests. (Please limit to 5 pages.)

PROFESSIONAL AUTOBIOGRAPHY: Please show how this interest in psychoanalysis evolved in your professional life. (Please limit to 5 pages.)

APPLICATION FOR PSYCHOANALYTIC TRAINING ELSEWHERE:

Institute_____ Date_____ Outcome _____

Institute_____ Date_____ Outcome _____

If you are applying for Adult training only, are you interested in the Child/Adolescent psychoanalytic training in the future? ☐ **Yes** ☐ **No**

FINANCING: Please outline your plan for financing your training.

REFERENCES: Please give names and mailing addresses of three persons to whom we can write to who know your clinical work with patients. Please do not include your therapist.

1.

2.

3.

How did you hear about the Denver Institute for Psychoanalysis's analytic program?

ATTESTATION STATEMENTS. Please initial you have read the following:

_____ **I attest that this information provided by me is true and accurate**

_____ **I understand my application could be denied if I have not been truthful**

_____ **I understand I am obligated to update the Denver Institute for Psychoanalysis if my situation changes.**

_____ **I understand I will be required to show proof of vaccination (COVID-19)**

Signature_____ **Date** _____

Please Enclose:

1) $400 application fee. Check made payable to the Denver Institute for Psychoanalysis
2) A transcript of your medical or graduate school record.
3) CV; Scientific Resume
4) Copy of medical or specialty license
5) Copy of certification
6) Copy of malpractice insurance coverage page
7) Copies of publications
8) Personal autobiography
9) Professional autobiography
10) Case summary (*or summaries if applying to combined programs)
11) Proof of vaccination status (prior to matriculation)

PLEASE NOTE: Admission and matriculation are two separate steps. Admission with recommendations for the candidate prior to matriculation are in the best interest of the candidate.

ADDENDUM: **MALPRACTICE AND ETHICS INFORMATION**

1)	**Have your clinical privileges ever been suspended or withdrawn?**	☐ No	☐ Yes
2)	**Have any malpractice claims ever been made against you, including claims currently pending, or settled, and that have resulted in judgements against you?**	☐ No	☐ Yes
3)	**Has your professional license ever been revoked, suspended, or had limitations put on it?**	☐ No	☐ Yes
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?**	☐ No	☐ Yes
5)	**Has your DEA license ever been suspended or revoked?**	☐ No	☐ Yes
6)	**Have you ever been denied professional liability insurance?**	☐ No	☐ Yes
7)	**Have you ever been excluded or barred from participating in any heath care plan, private or public?**	☐ No	☐ Yes

Please explain any "yes" answers in detail:

Signature **Date**