

PLEASE NOTE APPLICATION DEADLINE IS April 1st IN EVEN-NUMBERED YEARS

APPLICATION FOR ADMISSION



2-YEAR ADULT PSYCHODYNAMIC PSYCHOTHERAPY PROGRAM (PTP)

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

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 _____ Choose one:

PRESENT POSITION: _____

PREFERRED PRONOUNS: _____

CELL PHONE:

PRACTICE WEBSITE:

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 of three people who know your clinical work with patients, **whom you have already asked to send us** a reference letter by mail, email or fax.)

- _____

- _____

- _____

How did you hear about the PTP Program at the Denver Institute for Psychoanalysis?

ATTESTATION STATEMENTS:

I attest that this information provided by me is true and accurate Yes No

I understand my application could be denied if I have not been truthful Yes No

I understand I am obligated to update the Denver Institute for
Psychoanalysis if my situation changes Yes No

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

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 COMPLETED APPLICATION TO:

The Denver Institute for Psychoanalysis
Mail Stop F546
1890 N. Revere Court
Aurora, CO 80045