Psychotherapy Center for Gender and Sexuality
At The Institute for Contemporary Psychotherapy
1841 Broadway, 4th floor * New York, NY 10023 * (212) 333-3444

PCGS Program Application

Name: _____ Credentials_____

Social Security Number:_____ Date of Birth_____

Address (Home): _____ Phone:_____

_____

Address (Office): _____ Phone:_____

_____

Graduate Educational Record

School	Dates	Major	Degree	Date Graduated

Postgraduate Training

Institution	Courses

Licensure/Certification

Do you have state a license or certificate? __ No __ Yes, If yes please provide
State _____and license or certificate Number _____

Professional Experience

Please report current experience first *(Attach Resume and use this form).*

Name of Institution:_____

Address:_____

Starting Date:_____ **Ending Date:**_____ **Hours per week:** ____ **Total hours:**_____

Name of Supervisor: _____ **Total hours:**_____

Please describe the nature of your work performed at this institution, (e.g., diagnosis, individual/group therapy, etc.), the volume of patients seen, the nature of the patient population, (e.g., adults, children, adolescents, families), the average length of treatment for patients seen in psychotherapy, and the general orientation of your work at this institution. ***(If additional space is needed, please attach).***

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Name of Institution:_____

Address:_____

Starting Date:_____ **Ending Date:**_____ **Hours per week:** ____ **Total hours:**_____

Name of Supervisor: _____ **Total hours:**_____

Please describe the nature of your work performed at this institution, ***(If additional space is needed, please attach).***

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Psychotherapy Practice

1. **Are you currently in private practice? __No __Yes; *If yes please provide the following information:***
   Approximate hours per week: Individual _____ Group _____Other _____
   Is your work supervised? __No __Yes __Yes, in the past

2. **Are you currently working in an agency? __No __ Yes, *If Yes please provide the following information***
   Agency's Name_____ and Start Date _____
   Approximate hours per week: Individual _____ Group _____Other _____
   Is your work supervised? __No __Yes __Yes, in the past

3. **Please indicate the names of supervisors and dates of supervision for your psychotherapy experience (*If additional space is needed, please attach*):**

   Name:_____ From: _____to_____

   Name:_____ From: _____to_____

   Name:_____ From: _____to_____

4. **Please describe the work you do in your psychotherapy practice, including information on the nature of your patients (e.g., age range, diagnostic categories), the duration of treatment, and your work's general orientation. *If additional space is needed, please attach.***

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Total number of hours worked in psychotherapy – Individual: ____Group: ____ Other _____

5. **Please indicate in the space provided below the reasons for your interest in the LGBTQ Clinical Certificate Program, as well as any experience you have had working with the LGBTQ community (*If additional space is needed, please attach).***

Professional Affiliations (*If additional space is needed, please attach)*

1. _____
2. _____
3. _____
4. _____

References

Please provide the following information of at least two supervisors familiar with your clinical work, and request that each send us a letter of recommendation.

1. **Name** _____ **Title**_____
   Address_____
2. **Name** _____ **Title**_____
   Address_____
3. **Name** _____ **Title**_____
   Address_____

Please tell us how you learned about our training program.

_____

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Signature_____ **Date:**_____