Institute for Contemporary Psychotherapy
1841 Broadway, New York, N.Y. 10023-7603
(212) 333-3444 Fax: (212) 333-5444

PCGS Training Application

Questions about this application? Contact Tobin Berliner, Program Manager, at: pcgs@icpnyc.org or 212-333-3444 x 109

Name_____ D.O.B / / S.S._____

Address_____ Home Phone _____

_____ Work Phone _____

Marital Status/Partner(optional)_____ No. of Children_____

N.Y.S. License or certificate number_____

Are you eligible for insurance reimbursement?_____ If not check here ☐

EDUCATIONAL RECORD

School	Dates Attended	Major Degree	Date Graduated

POSTGRADUATE TRAINING (List courses and training programs)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PROFESSIONAL EXPERIENCE

(Include all relevant work experience starting with most recent)

Name of Institution _____

Address_____

Starting Date_____ **Ending Date**_____

Hours per week _____**Total Hours**_____

Percentage of time spent in: Diagnosis_____ **Ind. Ther.**_____

Other (specify)_____

Please describe your responsibilities including: clinical experience; types of modalities used, diagnostic range of patients/clients frequency and focus of supervision.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of Supervisor_____**Hrs. per Week**_____

Address of Supervisor_____**Total Hrs**._____

Name of Supervisor_____**Hrs. per Week**_____

Address of Supervisor_____**Total Hrs**._____

Total No. of patients seen in Psychotherapy_____

(If additional space is needed please attach sheet using above as a guide)

PRIVATE PRACTICE

Are you in private practice?_____ When did you begin _____

Approximate hrs. per week: Individual_____ Group_____ Other _____

Is your work supervised?_____Yes, in the past_____

List names, addresses and dates of supervision:

Name From_____ To_____

Address

Name From_____ To_____

Address

Total No. of patients in Psychotherapy_____

Briefly describe your practice in terms of what type of patients you work with; what type of issues you focus on, age range of patients; any specialties you have developed and approximately how many hours per week you see patients.

_____
_____
_____
_____
_____
_____

REFERENCES:

List names and titles of three persons who are familiar with your clinical experience. Please request that these three people send a letter of recommendation.

1._____

2._____

3._____

PROFESSIONAL AFFILIATIONS

_____
_____
_____

On what date would you be available to begin working at the Institute?

_____

Which days and hours are you available to work? (List days of week and hours for each day) Give as many choices as you can.

_____
_____
_____
_____
_____

Will you be using: private office_____ ICP office_____

Date:_____ **Signature**_____