Institute for Contemporary Psychotherapy
33 West 60th Street, 4th Fl, New York, N.Y. 10023-7603
(212) 333-3444 Fax: (212) 333-5444

PCGS Training Application

Fill this out online at https://icpnyc.org/pcgs/certification/

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

Legal Name____

Name (if different from above) ____

Address__________________________________ **Home Phone** ___________

____ **Work Phone** ___________

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)

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PROFESSIONAL EXPERIENCE

(Include all relevant work experience starting with most recent)

Name of Institution ____

Address____

Starting Date___________________ **Ending Date**______________________

Hours per week _________________**Total Hours**______________________

Total Patient Hours per Week ________________________

Other (specify)________________________

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

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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)

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PRIVATE PRACTICE

Are you in private practice?________ When did you begin ________________

Approximate hrs. per week: Individual________ Group_______ Other ______

Is your work currently supervised?________________________ 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.

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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 to pcgs@icpnyc.org with the subject line "Recommendation for [Candidate Name]"

1.____

2.____

3.____

PROFESSIONAL AFFILIATIONS

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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.
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Will you be using: ☐ private office________ ☐ ICP office________ ☐ Telehealth________

Date:____________________ **Signature**____

The Institute for Contemporary Psychotherapy provides training without regard to race, color, religion, sex, national origin, age, disability, marital status, sexual orientation, gender expression, gender identity or any other classification protected under applicable federal, state and local law.