

Cleveland Child & Adolescent Psychoanalytic Training Program
Application

Cleveland Psychoanalytic Center
2460 Fairmount Blvd. #312
Cleveland Heights, Ohio 44106

Tel: 216-229-5959 www.psychoanalysiscleveland.org Fax: 216-229-7321

Hanna Perkins Center
19910 Malvern Road
Shaker Heights, Ohio 44122

Tel: 216- 991-4472 www.hannaperkins.org

Date of Application: _____

PLEASE TYPE OR PRINT
PERSONAL INFORMATION

Name in Full: _____ Degree: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

E-mail Address: _____

Occupation/Present Position: _____

Use additional pages as needed to expand on any part of this application.

PLEASE INCLUDE THE FOLLOWING WITH THIS APPLICATION

- **Current Curriculum Vitae**
- **Arrange to have sent transcripts of college and graduate schools**
- **Copy of License**
- **Copy of Professional Liability Insurance, if applicable**
- **Arrange for Letters of Reference to be sent**
- **Application fee of \$50.**

-CHILD AND ADOLESCENT CLINICAL EXPERIENCE

Location	Activities	Date

Continue on a separate page if needed.

PRESENT OR PREVIOUS PSYCHOANALYTIC TRAINING

Institute/ Center	Academic Years Completed	Dates

**PROFESSIONAL LICENSES AND/OR CERTIFICATIONS
IN YOUR FIELD**

Enclose a copy of your current license to practice or other certifications if applicable.

Licensing or Certifying Body	Date

PROFESSIONAL LIABILITY INSURANCE

Enclose a copy or proof of insurance to this application if applicable.

Insurance carrier: _____ Policy No: _____

Expiration date: _____ Amount of coverage: _____

If the answer to any of the following questions is YES, give full details on a separate page.

Have you ever been charged with a criminal offense, ethics violation or a civil complaint of a professional nature? Yes No

Has your license ever been suspended, revoked or limited? Yes No

Have your professional privileges ever been limited or denied, or have you been censured by a professional organization? Yes No

Are you now or have you ever been diagnosed with a problem with substance abuse? Yes No

Have you ever been engaged in any sexual conduct with any of your current or former patients or any current or former patient's spouse or any person with a direct relationship to the patient or former patient (e.g., a guardian, blood relative of the patient or spouse, or any person sharing the patient's domicile?) Yes No

Are you now/have you even been in psychoanalysis? Yes No

If yes, give treatment dates and approximate number of hours.

STATEMENT REGARDING THE DEVELOPMENT OF YOUR INTEREST IN CHILD ANALYSIS:

Use additional pages to expand on your statement if you wish.

REFERENCES

Names and addresses of three persons well acquainted with you and with your professional work who are willing to provide letters of reference:

Name	Address
<hr/>	
<hr/>	
<hr/>	

Have references sent to:

**Hanna Perkins Center/Cleveland Psychoanalytic Center
Child & Adolescent Psychoanalytic Training Program
Attention: Ms. Barbara Streeter, Faculty Chair
Hanna Perkins Center
19910 Malvern Road
Shaker Heights, Ohio 44122
tel: 216-929-0194**

Consent for Letter of Reference:

I, _____ hereby give my consent to:
Print of Type Name

Name: _____

Address: _____

Phone Number (s): _____

to provide information regarding me to representatives of the Cleveland Child & Adolescent Psychoanalytic Training Program. I understand that letters of reference are required by the Child and Adolescent Analytic Training Program as part of my application to the Training Program and that information contained in such letters will be kept confidential within the confines of the Cleveland Child & Adolescent Psychoanalytic Training Program's Faculty and Education Committee.

Signature of Applicant

Date

Hanna Perkins Center/Cleveland Psychoanalytic Center Child & Adolescent Analytic Training Program: Application –

Section I: Please sign the following statement:

I certify that all information provided on this Application, or submitted with it, is accurate to the best of my knowledge. I specifically authorize the HPC/CPC Child & Adolescent Psychoanalytic Training Program and its authorized representatives to consult with the third parties whose names I have given either herein or otherwise, as well as with any third parties whose names I may in the future provide as references, concerning further information bearing on my application.

Signature:

Print name

Date

Return the completed application and check for the \$50 application fee to:

Ms. Barbara Streeter, Faculty Chair
Hanna Perkins Center
19910 Malvern Road
Shaker Heights, Ohio 44122
Phone: 216-929-0194

Make check payable to: **Hanna Perkins Center**
On memo line of check please indicate: **CAPT app. fee**

The Cleveland Psychoanalytic Center and the Hanna Perkins Center do not discriminate on the basis of sex, race, sexual orientation, creed, religion or ethnic origin.