THE AMERICAN INSTITUTE FOR PSYCHOANALYSIS

329 EAST 62 ND ST • NEW YORK, NY 10065 • (212) 838-8044 • aipnyc.org • info@aipnyc.org

APPLICATION FOR TRAINING

I WISH TO APPLY FOR TRAINING (Circle one: **A: Program in Psychoanalysis; B: Program in Psychodynamic Psychotherapy**) AT THE AMERICAN INSTITUTE FOR PSYCHOANALYSIS, AND I SUBMIT HEREWITH INFORMATION RELEVANT TO THIS APPLICATION.

I WISH TO APPLY FOR WORK-STUDY OPPORTUNITIES FOR TUITION REDUCTION (Circle one): YES NO (If yes please attach resume to this application. A separate interview will be required).

TWO COPIES OF THIS FORM ARE REQUIRED AND MUST BE ACCOMPANIED BY AN APPLICATION FEE OF **$125.00. Applications can be mailed to our address above or emailed to info@aipnyc.org. The application fee is payable by check to AIP or via PayPal at** aipkh@aol.com

DEADLINE FOR APPLICATION: May 15th

Name: _____

Address: _____

_____

Telephone: (H) _____

(C) _____

E-mail: _____

Social Security Number: _____

Date of Birth: _____

Citizen of the United States: Yes _____ No_____

Country of Birth: _____

Have you ever applied to the American Institute for Psychoanalysis before? Yes _____ No_____

If yes, please fill in date: _____

How did you hear about the Training Programs of the the American Institute for Psychoanalysis?

_____

UNDERGRADUATE EDUCATION

_____	_____	_____
INSTITUTION	DATES	DEGREE
_____	_____	_____
INSTITUTION	DATES	DEGREE

PROFESSIONAL EDUCATION (MD, PhD, PsyD, MSW, RN-MS)

_____	_____	_____
INSTITUTION	DATES	DEGREE
_____	_____	_____
INSTITUTION	DATES	DEGREE
_____	_____	_____
INSTITUTION	DATES	DEGREE
_____	_____	_____
INSTITUTION	DATES	DEGREE

EXPERIENCE: BEGINNING WITH THE CURRENT YEAR, LIST YOUR PROFESSIONAL EXPERIENCE DURING THE PAST FIVE (5) YEARS. PLEASE BE CERTAIN TO INCLUDE THE NAME AND ADDRESS OF EACH OF YOUR EMPLOYERS.

_____

1)

_____

2)

_____

3)

_____

4)

_____

5)

Licensure Qualifying Program Applicants SKIP this section and go to PAGE 5

WHERE DID YOU PERFORM YOUR FIELD EXPERIENCE AND WORK EXPERIENCE? STATE MONTH AND YEAR OF COMMENCEMENT AND TERMINATION IN EACH FIELD PLACEMENT.

1)

NAME OF INSTITUTION_____

ADDRESS_____

STARTING DATE_____ ENDING DATE_____ NO. OF HOURS_____

NAME (S) OF YOUR DIRECT SUPERVISORS_____

_____

_____

NO. OF HOURS OF SUPERVISION EACH MONTH_____

2)

NAME OF INSTITUTION_____

ADDRESS_____

STARTING DATE_____ ENDING DATE_____ NO. OF HOURS_____

NAME (S) OF YOUR DIRECT SUPERVISORS_____

_____

_____

NO. OF HOURS OF SUPERVISION EACH MONTH_____

3)

NAME OF INSTITUTION_____

ADDRESS_____

STARTING DATE_____ ENDING DATE_____ NO. OF HOURS_____

NAME (S) OF YOUR DIRECT SUPERVISORS_____

_____

_____

NO. OF HOURS OF SUPERVISION EACH MONTH_____

4)

NAME OF INSTITUTION_____

ADDRESS_____

STARTING DATE_____ ENDING DATE_____ NO. OF HOURS_____

NAME (S) OF YOUR DIRECT SUPERVISOR (S) _____

_____

_____

NO. OF HOURS OF SUPERVISION EACH MONTH_____

PRIVATE PRACTICE: ARE YOU ENGAGED IN PRIVATE PRACTICE? YES_____ NO _____

IF **YES**, WHEN DID YOU BEGIN YOUR PRIVATE PRACTICE? _____

APPROXIMATELY HOW MANY HOURS A WEEK DO YOU SPEND IN PRIVATE PRACTICE? _____

IS YOUR WORK SUPERVISED? YES _____ NO _____

LIST NAMES, ADDRESSES AND TELEPHONE NUMBERS OF YOUR SUPERVISORS AND THE DATES DURING WHICH THEY SUPERVISED YOUR WORK

_____

_____

_____

ARE YOU CURRENTLY IN PERSONAL PSYCHOANALYSIS OR PSYCHOTHERAPY? YES___ NO___

IF **YES**, WHEN DID YOU BEGIN? (MONTH AND YEAR) _____

NAME OF YOUR ANALYST /THERAPIST _____ HOURS PER WEEK ___

WITH WHAT SCHOOL/INSTITUTE IS YOUR ANALYST (THERAPIST) AFFILIATED?

_____

_____

LIST ALL PREVIOUS ANALYSTS (THERAPISTS), AFFILIATIONS, DATES AND FREQUENCY _____

_____

_____

_____

REFERENCES: LIST THE NAMES AND ADDRESSES OF TWO OF YOUR MOST RECENT SUPERVISORS AND ONE OTHER PERSON WITH WHOM YOU HAVE WORKED, WHO ARE WILLING TO SPONSOR THIS APPLICATION. **YOU ARE RESPONSIBLE TO ASK THEM TO WRITE TO US DIRECTLY REGARDING YOUR PROFESSIONAL ABILITY AND INTEGRITY**. PLEASE DO NOT SEND A LETTER OF REFERENCE FROM A PSYCHOANALYST OR PSYCHOTHERAPIST WITH WHOM YOU WERE IN TREATMENT.

1)
_____

2)
_____

3)
_____

PLEASE COMPLETE THE FOLLOWING:

ARE THERE ANY JUDGEMENTS OR SETTLEMENTS OF MALPRACTICE AGAINST YOU?

YES_____ NO_____

ARE THERE ANY PENDING MALPRACTICE ACTIONS?

YES_____ NO_____

HAVE THERE EVER BEEN, OR ARE THERE NOW' ANY FINDINGS OF PROFESSIONAL MISCONDUCT AGAINST YOU?

YES_____ NO_____

HAS DISCIPLINARY ACTION OF ANY SORT EVER BEEN TAKEN AGAINST YOU BY A SUPERVISOR, EDUCATIONAL OR TRAINING INSTITUTION, HEALTH CARE INSTITUTION, PROFESSIONAL ASSOCIATION, OR LICENSING? CERTIFICATION BOARD?

YES_____ NO_____

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE PAGE.

WRITE A STATEMENT AS TO HOW YOU BECAME INTERESTED IN PURSUING POSTGRADUATE TRAINING. WHY ARE YOU SEEKING TRAINING AT THIS INSTITUTE? BRIEFLY DISCUSS YOUR ORIENTATION IN TREATING PATIENTS.

(ALTERNATIVE ESSAY) COULD YOU BRIEFLY TELL US WHAT YOU FEEL WE SHOULD KNOW ABOUT YOU SO THAT WE CAN BEST EVALUATE YOUR APPLICATION FOR POSTGRADUATE TRAINING.

_____ _____

SIGNATURE DATE

APPLICATION PROCEDURE

1. Please mail application to the American Institute for Psychoanalysis at 329 Easy 62nd St. New York, NY 10065 or email to info@aipnyc.org

2. Please include a copy of your license or certificate to practice. If you have no license or certificate, include an explanation and a copy of your professional diploma.

3. Please enclose your application fee of $125.00 payable by check to AIP or via PayPal at **aipkh@aol.com** by May 15th, 2024.

4. Once we receive your completed application, you will receive the names of the faculty members with whom to arrange interviews.

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To the Registrar:

I hereby authorize the American Institute for Psychoanalysis (AIP) to provide copies of my application, letters of reference, license and registration which are obtained as part of the application process to the Karen Horney Clinic or any other clinical facility which requires them as part of my work related to my training at the AIP. Should I join an AIP training program, I also authorize the release of copies of supervisors' and instructors' reports to clinical facilities that I utilize as part of my clinical experience.

_____ _____
Signature Date

_____
Print Name