

THE BOSTON PSYCHOANALYTIC SOCIETY AND INSTITUTE, INC.
15 Commonwealth Avenue, Boston, MA 02116

APPLICATION FOR ADMISSION

to the

**ONE-YEAR FELLOWSHIP PROGRAM
IN CHILD PSYCHOANALYTIC PSYCHOTHERAPY**

APPLICATION DEADLINE: July 1

Name: _____

Name in Full: _____

(last)

(first)

(middle)

Address: *(indicate preferred mailing address)*

Office: _____

_____ Telephone: _____

Home: _____

_____ Telephone: _____

Academic Degrees *(college, graduate school, dates of graduation)*

Clinical Training *(in psychiatry, psychology, social work, counseling, psychiatric nursing include full names and addresses of supervisor; give dates)*

Current Employment *(Include full names and addresses of supervisors; give dates)*

Place of work, nature and description of position: _____

Current number of patients seen by you in psychotherapy **(IF APPLICABLE)**: _____

Type of patients seen: _____

Other Professional Interests and Activities *(e.g. research, teaching, community work)*
(Include publications and reprints if possible)

