

**NEW ORLEANS–BIRMINGHAM PSYCHOANALYTIC CENTER  
CHILD AND ADOLESCENT PSYCHOANALYTIC TRAINING PROGRAM**

**APPLICATION**

Name in Full: \_\_\_\_\_ Degree \_\_\_\_\_

Address: (Check preferred mailing address)

\_\_\_\_\_ Office: \_\_\_\_\_

Office Telephone: \_\_\_\_\_

\_\_\_\_\_ Home: \_\_\_\_\_

Preferred Email Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Children (ages): \_\_\_\_\_

Nearest Responsible Relative: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

**UNDERGRADUATE EDUCATION**

College	Address	Date	Degree
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**GRADUATE EDUCATION**

College	Address	Date	Degree
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Describe areas of research, if applicable, on a separate page.

**POST GRADUATE EDUCATION**

Institution	Address	Dates	Nature of Training
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Indicate the number of hours per week if not full time.

**BOARD CERTIFICATIONS**

Certifying Organization	Date
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**CHILD AND ADOLESCENT CLINICAL EXPERIENCE**

Location	Activities	Date
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<hr/>		

Continue on a separate page if needed.

**ACADEMIC APPOINTMENTS**

Position and Activities	Date
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Continue on a separate page if needed.

**SCIENTIFIC PUBLICATIONS AND PRESENTATIONS**

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Continue on a separate page if needed.

**MEMBERSHIPS IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS**

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Continue on a separate page if needed.

**CURRENT HOSPITAL, CLINICAL OR ORGANIZATIONAL AFFILIATIONS**

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Continue on a separate page if needed.

**PRESENT OR PREVIOUS PSYCHOANALYTIC TRAINING**

Institute/Center	Academic Years Completed	Dates
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Describe your experience conducting psychotherapy and/or psychoanalysis, including a description of your child and adolescent caseload, on a separate page.

Are you in good standing at your present Institute/Center?     Yes     No  
(Please explain)

**MEDICAL LICENSES OR CERTIFICATION IN  
YOUR PROFESSIONAL FIELD**

*Enclose a copy of your current license to practice or other certification(s)*

Licensing or Certifying Body	Date
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**PROFESSIONAL LIABILITY INSURANCE**

*Append a copy or proof of insurance to this application*

Insurance carrier: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Expiration date: \_\_\_\_\_ Amount of coverage: \_\_\_\_\_

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

Has your license to practice in any jurisdiction ever been limited, suspended, revoked, denied or have you been subject to any administrative or disciplinary proceedings regarding your license to practice in any jurisdiction? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have your privileges to practice in any hospital, clinic, or other facility ever been limited or restricted or subjected to required supervision? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have any suits been filed against you or have any judgments or settlements been made in response to a complaint regarding professional liability? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have any staff or clinic or other clinical privileges or memberships ever been refused, suspended, diminished, revoked, or subjected to administrative or clinical supervision, or have any privileges not been renewed at any academic institution, hospital, clinic., or other teaching or practice situation? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever been involved in a legal action or appeared before an Ethics Committee in relation to your professional work or license? \_\_\_\_\_ Yes \_\_\_\_\_ No

### **OPTIONAL**

1. You are invited to enclose a brief autobiography including a description of the development of your interest in child and adolescent psychoanalysis.
2. Add any additional information which you feel would be helpful in evaluating your suitability for child and adolescent analytic training.

The New Orleans–Birmingham Psychoanalytic Center requires at least one interview for admission to the child analytic training program. The interview may be conducted by telephone or audio-video link for non-local applicants.

### **REFERENCES**

Names and addresses of three persons well acquainted with you and with your professional work to whom we may write for references.

Name

Address

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## WAIVER OF CLAIMS

I understand that the decision as to whether I am qualified for acceptance to the Center's training program vests solely and exclusively in the Center, and that its decision is final. I agree to hold the Center, its directors, officers, members, representatives and agents free from any complaints or claims or demands for damage or otherwise by reason of any omission or commission that they, or any of them, may take in connection with this application, the interview and deliberative process or the decision by the Institute for admission to its training program.

## PLEDGE

If accepted, I agree to abide by the rules and decisions of the Psychoanalytic Education Committee and pledge myself neither to conduct independent psychoanalytic treatment nor to represent myself as a practitioner of psychoanalysis until I am authorized to do so by the Psychoanalytic Education Committee of an Accredited Center, Institute or Society of the American Psychoanalytic Association.

*Attach a recent photograph here*

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Signature

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Date

Return the completed application and a check for the \$100 application fee to:

New Orleans–Birmingham Psychoanalytic Center  
3624 Coliseum Street  
New Orleans, LA 70115

The New Orleans–Birmingham Psychoanalytic Institute does not discriminate on the basis of sex, race, sexual orientation, creed, religion or ethnic origin.