

# Florida Psychoanalytic Center

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## Active Membership Application

**Please complete all parts of this form and mail, email or fax, along with a Current CV, to The Florida Psychoanalytic Center. Your application will be reviewed at our next Center meeting.**

### Personal Information:

Name: \_\_\_\_\_ Title/Degree: \_\_\_\_\_

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

Email address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (DOB will only be used to establish membership)

### Education and Training:

Graduate/Medical School: \_\_\_\_\_ Year: \_\_\_\_\_

Residency/Clinical Internship: \_\_\_\_\_

Other Graduate Training: \_\_\_\_\_ Year: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

Liability Insurance Policy (name of carrier): \_\_\_\_\_

Policy Number: \_\_\_\_\_ Amount of Coverage: \_\_\_\_\_

Other Affiliation: \_\_\_\_\_

(Please attach copies of your Professional License and Professional Liability Insurance Policy)

### Ethical Disclaimer:

I hear by certify that to my knowledge:

1. Have there ever been any findings of unethical or unprofessional conduct?

\_\_\_\_ No \_\_\_\_ Yes (If "yes", please explain.)

2. Are there any current or pending charges or allegations of unethical or unprofessional conduct?

\_\_\_\_ No \_\_\_\_ Yes (If "yes", please explain.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_