

Florida Psychoanalytic Center

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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. Once your application has been approved, you will be notified and asked to pay the annual dues of \$175.00 for adjunct membership.

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: _____