Florida Psychoanalytic Center

4649 Ponce de Leon Blvd. Suite 303 Coral Gables, FL 33146

Member Application

Type of Membership:

_____ Active _____ Affiliate _____ Clinician _____ Corresponding ____ Honorary _____ Student

Personal Information:

Name: _____

Title/Degree/or Student Status: _____

Office Address: _____

Email address: _____

Office Phone: _____ Fax: _____

Home Phone: _____ Cell: _____

For Student Member Applicants only:

Current Training Institution: _____

For Active Member Applicants only:

Psychoanalytic Training:

Institute Where You Trained: _____

Year Graduated: _____

Education and Training:

Graduate/Medical School: _____

Year Graduated: _____ Or, for Student Members, Year Expected to Graduate: _____

Residency/Clinical Internship: _____

Year Completed: _____ Or, for Student Members, Year Expected to Complete: _____

Other Graduate Training: _____

Year Completed: _____ or Expected to Complete: _____

For Active, Affiliate, Clinician, Corresponding, and Honorary Member Applicants only: (Student member applicants may skip this section)

License Number: _____ State: _____

Liability Insurance Policy (name of carrier): _____

Policy Number: _____ Amount of Coverage: _____

(Please attach copies of your Professional License, Professional Liability Insurance Policy and a copy of your most current CV.)

Other Affiliation: _____

Professional Information:

Place(s) of Practice (Private Practice, Hospital, University, Etc.):

_____

_____

_____

Years in Practice as a Licensed Clinician: _____

Ethical Disclaimer:

By signing below, I certify that the following statements are true:

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: _____