FLORIDA PSYCHOANALYTIC CENTER

PSYCHODYNAMIC PSYCHOTHERAPY COURSE

APPLICATION

Date:_____

Name:_____

Profession/Degree:_____

Licensed in Florida? If so, please put license number. If not, what is your professional status?: _____

_____

CONTACT INFORMATION:

Office Address:_____

City:_____State:_____Zip Code_____

Office phone: _____

Cell phone: _____

Email Address: _____

Home Address:_____

City:_____State:_____Zip Code_____

Home phone: _____

GRADUATE EDUCATION:

School_____

Degree _____ Dates:_____

School_____

Degree _____ Dates:_____

School_____

Degree _____ Dates:_____

RESIDENCIES, INTERNSHIPS, PROFESSIONAL TRAINING: (State type of program, Institution, Dates)

_____

_____

_____

OTHER PROFESSIONAL EXPERIENCE:
(Clinical work, teaching, research, post-graduate courses)

_____

_____

_____

CURRENT PROFFESSIONAL ACTIVITIES:

_____

_____

_____

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

_____ _____
Signature Date

Fees are $600.00 per semester due in September and January each year:
Please make checks out to:
The Florida Psychoanalytic Society
4649 Ponce de Leon Blvd., Suite 303, Coral Gables, Fl. 33146