

Florida Psychoanalytic Center

4649 Ponce de Leon Blvd. Suite 303

Coral Gables, FL 33146

Application for Advanced Clinical Consultation Group

Personal Information:

Name: _____

Title/Degree: _____

Office Address: _____

Email address: _____

Cell Phone: _____

Education and Training:

Graduate School/Medical School: _____

Year Graduated: _____

Residency/Clinical Internship: _____

Year Completed: _____

License Number: _____ State: _____

Professional Information:

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

Years in Practice as a Licensed Clinician: _____

Number of Hours (approximately) of Outpatient Individual Therapy Post- Licensing (We require a minimum of 5000 clinical hours. That is roughly 20 clinical hours per week, 1000 per year, for 5 years):

Didactic Training Experiences in Psychoanalytic or Psychodynamic Theory or Technique, i.e., training programs, seminars, workshops, or conferences:

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 below.)

2. Are there any current or pending charges or allegations of unethical or unprofessional conduct?
_____ No _____ Yes (If "yes", please explain below.)

Please attach a copy of your most current CV.

Signature: _____ **Date:** _____

Explanation of findings of unethical or unprofessional conduct:

Explanation of current or pending charges or allegations of unethical or unprofessional conduct: