

BIPACT

BROOKHAVEN INSTITUTE FOR PSYCHOANALYSIS

AND CHRISTIAN THEOLOGY

APPLICATION FOR ENROLLMENT

(please print or type)

Name _____ Date of Birth _____

Home Address _____

City/State/Zip
Code _____

Home Telephone with Area Code _____

E-mail
Address _____

Professional Address _____

City/State/Zip
Code _____

Work Telephone with Area Code _____

Please indicate preferred mailing address: Home _____ Office _____

Citizenship _____ Social Security Number _____

Professional Licensure (type, state,
date) _____

Professional Liability Insurance (name of company, policy number, effective dates) _____

(Upon acceptance, applicant must send copies of licensure and certificate of liability insurance to the Registrar annually during training.)

FILL IN AS APPLICABLE:

ACADEMIC TRAINING

Institution, Dates Attended, Degree

Undergraduate_____

Graduate_____

Postgraduate_____

CLINICAL TRAINING

Institution, Name of Program, Position, Dates

Internship_____

Residency_____

Fellowship_____

Other Professional Training (specify)_____

BOARD CERTIFICATION (certifying body, date)

PRIVATE PRACTICE

Type of Practice, Location, Hours/Week, Dates

OTHER PROFESSIONAL WORK EXPERIENCE (beginning with most recent)

Place of
Employment _____

Dates _____ Hours/Week _____

Position _____

Nature of Work _____ Supervisor _____

Place of
Employment _____

Dates _____ Hours/Week _____

Position _____

Nature of Work _____ Supervisor _____

Place of
Employment _____

Dates _____ Hours/Week _____

Position _____

Nature of Work _____ Supervisor _____

Place of
Employment _____

Dates _____ Hours/Week _____

Position _____

Nature of Work _____ Supervisor _____

How many psychotherapy cases are you seeing currently? _____

OTHER INDEPENDENT SUPERVISION / CONSULTATION

Supervisor/Degree _____ Dates _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

Supervisor/Degree _____ Dates _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

Supervisor/Degree _____ Dates _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

ACADEMIC AND HOSPITAL APPOINTMENTS

Institution /Position /Dates

PERSONAL PSYCHOTHERAPY (Please do not list therapies of less than 20 sessions)

Psychotherapist/Degree _____ Dates _____

Frequency of sessions (times/wk) _____ Total number of sessions? _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

Psychotherapist/Degree _____ Dates _____

Frequency of sessions (times/wk) _____ Total number of sessions? _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

Psychotherapist/Degree _____ Dates _____

Frequency of sessions (times/wk) _____ Total number of sessions? _____

Psychoanalytic institute graduate (Y/N)? _____ Institute? _____

MEMBERSHIP IN PROFESSIONAL SOCIETIES

PROFESSIONAL ACTIVITIES (teaching, research, publications, community work – if lengthy, you may substitute your CV, if you wish)

REFERENCES

Please arrange to have one ministerial and two professional letters of reference sent to us on your behalf. One should be either the training director at your most recent place of academic or clinical training, or the person to whom you currently report; the other should be one who knows your current work with patients. (If your training was not recent, and if you have not recently had a person to whom you report, you may substitute a second person who knows your work with

patients.) Please send to each a copy of the Request for Letter of Reference Form (copies enclosed). Please list the names of each reference below:

Arrange, as well, for transcripts from your most recent training program to be sent by that program to Lowell W. Hoffman, Ph.D.

PERSONAL NARRATIVE

Please write a detailed summary concerning your interest in psychoanalytic training and why you desire to be a candidate at BIPACT (two full pages and not more than three full pages double-spaced).

Signature _____ Date _____

The application fee is \$100.00 (check payable to BIPACT), and is nonrefundable.

Please send completed application form, enclosures and check to:

Lowell W. Hoffman, Ph.D.

PO Box 425

Fogelsville, PA 18051