APPLICATION FOR ADMISSION
to the
BPSI TRAINING PROGRAMS IN PSYCHOANALYTIC PSYCHOTHERAPY:
THE ONE-YEAR FELLOWSHIP PROGRAM
IN PSYCHOANALYTIC PSYCHOTHERAPY
and
THE ADVANCED TRAINING PROGRAM
IN PSYCHOANALYTIC PSYCHOTHERAPY
2019-2020

APPLICATIONS ARE ACCEPTED BETWEEN DECEMBER 1, 2018 AND MARCH 29, 2019.
Interviews are scheduled in April and May.

NAME: ________________________________________________________________

Please indicate the program for which you wish to apply:

Adult Track in the One-Year Fellowship Program

Child Track in the One-Year Fellowship Program

Advanced Training Program (ATP)

Are you involved in one of BPSI’s joint PiP programs? If so, please mark which one:
Child___  Longwood___  MGH/McLean___  Psychology___

If you are in a PiP program, do you have a BPSI mentor, and if so, who?

________________________________________________________________________
Name in Full: 
(last) (first) (middle)

Date of Birth: __________________________

Address: (indicate preferred mailing address)

Office: __________________________

______________________________ Telephone: __________________________

Home: __________________________

______________________________ Telephone: __________________________

Email: __________________________


Academic Degrees (college, graduate school, dates of graduation)

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______________________________

______________________________

______________________________

Clinical Training (in psychiatry, psychology, social work, counseling, psychiatric nursing; include full names and addresses of supervisors; give dates). If you are applying to the Child Clinical Track in the Fellowship, please indicate your formal Child/Adolescent Training.

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Current Employment (Include full names and addresses of supervisors; give dates)

Place of work, nature and description of position: __________________________

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______________________________
Current number of patients seen by you in psychotherapy (IF APPLICABLE): _________________________

Types of patients seen (If you are applying to the Child Clinical Track, please note how many of your therapy patients are Child/Adolescent patients): ________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Other Professional Interests and Activities (e.g. research, teaching, community work; Include publications and reprints if possible)

________________________________________________________

________________________________________________________

Professional References (Applicant is responsible for requesting his or her references to send letters to this office by mail, fax, or email. Do not use your current or past psychotherapists as professional references).

Letters of Reference are DUE BY March 30, and interviews will not be scheduled until letters are received.

1. ____________________________
   (name) ____________________________
   (address) ____________________________

2. ____________________________
   (name) ____________________________
   (address) ____________________________

3. ____________________________
   (name) ____________________________
   (address) ____________________________

A TP applicants are required to be licensed and have current malpractice insurance. Fellows are not.

Are you currently licensed?       Yes ___
(required for ATP applicants)     No ___

If yes, please indicate State and date of licensure ____________________________

Do you have current malpractice insurance?       Yes ___
(required for ATP applicants)     No ___

If yes, please indicate current coverage and a copy of include your malpractice facesheet: ____________________________

Specialty Board Certification (Date): ____________________________
Statement: Please attach a brief essay (anywhere from a paragraph to two pages) about why you are seeking further training at this time and how you see the Fellowship or ATP fitting into your professional development.
Circle either yes or no (Not N/A) to each question. Provide details on a separate page for all YES answers. Please answer all questions.

All applicants:
1. Has any governmental authority, health care facility, group practice, professional society or association, or academic or educational facility brought charges or a complaint against you or imposed any discipline against you relating to your practice or professional conduct, including for any alleged violation of laws, rules, by-laws, standards of practice or ethics?  
   YES NO

2. Have you ever lost or voluntarily relinquished your license to practice in any state or territory?  
   YES NO

3. Have you withdrawn an application for a professional license or been denied a professional license for any reason?  
   YES NO

4. Have you ever been convicted of a felony, or have you been convicted in the last ten years of any misdemeanor or other criminal offense, other than a minor traffic violation or are you currently charged with any criminal offense?  
   YES NO

5. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment on, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?  
   YES NO

6. Have you ever engaged in a sexual or romantic relationship with a patient or former patient?  
   YES NO

1. CLAIMS MADE: Has any malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?  
   YES NO

2. CLAIMS RESOLVED: Has any malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?  
   YES NO

3. Has any lawsuit, other than a malpractice suit, which is related to your competency to practice, or your professional conduct in the practice of your discipline, been filed against your or been settled, adjudicated or otherwise resolved?  
   YES NO

4. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?  
   YES NO
As a condition of membership, I agree to report any changes in my licensing status, or any complaints or actions initiated against me by any governmental authority, health care facility, group practice, professional society or association, or academic or educational facility in regard to my practice or professional conduct or the institution against me of felony criminal charges. I agree to practice within the professional and ethical guidelines of both my licensing profession and the APsaA Ethics Standards, to abide by the provisions of the BPSI bylaws, and to comply with the procedures of the BPSI Ethics Committees (Ethics Committee Policies and Procedures) (MAC Policies and Procedures). I understand that the above documents, policies, and procedures may change from time to time.

Signature: ___________________________ Date: ________________

**Financial Policy:**
I understand that payment of annual tuition is a condition of training. Good financial standing is a condition to participate in the activities of BPSI including committee work, running for office, teaching, and supervising. Library Privileges and P-e-P, where applicable. I understand that if my tuition is in arrears I will be considered not in good financial standing, and until I redress the arrears through full payment or payments toward a payment plan, I understand my privileges at BPSI will be suspended. I understand that in case of financial hardship I may seek a confidential payment plan through the Finance Office.

Signature: ___________________________ Date: ________________

**Application Waiver:**
I have reviewed the complete application, the BPSI Bylaws (attached), the APsaA Ethics Standards and the current BPSI Ethics procedure (attached).

In applying for the Fellowship/Advanced Training Program in Psychoanalytic Psychotherapy at Boston Psychoanalytic Society and Institute (BPSI), I understand that BPSI’s Admissions Committee or its designees will review my application and references, and may make further inquiries about me, that these answers will be obtained under pledge of confidentiality, and that I am not entitled to, and will not ask for disclosure of these replies. I hereby release BPSI, its Members, officials, employees, and agents from any liability in connection with the acquisition and use of said information, and will hold them free from all damage and claims because of any action taken on this application or by reason of any subsequent action.

Signature: ___________________________ Date: ________________
THE FOLLOWING QUESTION IS TO BE COMPLETED ONLY BY APPLICANTS TO THE ADVANCED TRAINING PROGRAM IN PSYCHOANALYTIC PSYCHOTHERAPY

What mental health treatment and/or psychotherapy have you had? (give names, modality, frequency, and dates – we will not contact your present or previous treater(s))

Please return this form with a non-refundable application fee of $50.00 and a current Curriculum Vitae.

I hereby authorize the Boston Psychoanalytic Society and Institute, Inc. to write to any of the above-named in the application (excluding my therapists) for information about my qualifications and hereby release BPSI, its officials, employees, and agents from any and all liability in connection with the acquisition and use of said information.

Signed

____________________________

Date

The Boston Psychoanalytic Society and Institute, Inc. (BPSI) does not discriminate on the basis of race, creed, color, sex, age, national origin, handicap, or sexual preference in admissions, administration of its education programs, scholarship and loan programs, and employment.

10/26/2018