

**APPLICATION FOR ADMISSION - PSYCHOLOGISTS**

**Four** copies of this application form are required and must be accompanied by an application fee of \$100. This fee is not refundable. Applications must be submitted on or before May 1<sup>st</sup>. Submit to: Director of Training, 20 West 74th Street, New York, NY 10023.

**WILLIAM ALANSON WHITE INSTITUTE  
of Psychiatry, Psychoanalysis and Psychology  
20 West 74th Street, New York, NY 10023**

Date of Application\_\_\_\_\_

Name in Full\_\_\_\_\_ Date of Birth\_\_\_\_\_

Address\_\_\_\_\_ Phone\_\_\_\_\_

(professional)

Address\_\_\_\_\_ Phone\_\_\_\_\_

(residence)

Email:\_\_\_\_\_

**Educational Record**\*: Include all collegiate, post-graduate, professional and technical education, with names and locations of institutions, dates attended and degree or certificate received. In each case, note month as well as year.

NB: As stated in our bulletin, our charter requires your Ph.D. (or Psy.D.) be in Clinical Psychology. Training at White may be used to fulfill New York State licensing requirements.

\*An official transcript of post-baccalaureate study is required.

**HOSPITAL WORK:** Where did you serve your internship? (One year of full-time work is the required minimum). State Month and Year of starting and stopping work in each hospital, and total number of hours in each.

Name of Hospital\_\_\_\_\_

Address\_\_\_\_\_

Starting Date\_\_\_\_\_ Ending Date\_\_\_\_\_ No. of Hours\_\_\_\_\_

Percentage of time spent in:  
Diagnosis\_\_\_\_\_ Research\_\_\_\_\_ Group Therapy\_\_\_\_\_ Individual Therapy\_\_\_\_\_

Other (specify)\_\_\_\_\_

Name(s) of your direct supervisors\*\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Please give current addresses if different from above, if possible)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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No. of hours of supervision each month\_\_\_\_\_

Percentage of time spent on: Closed wards\_\_\_\_ Open wards\_\_\_\_ Out patient service\_\_\_\_

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Name of Hospital\_\_\_\_\_

Address\_\_\_\_\_

Starting Date\_\_\_\_\_ Ending Date\_\_\_\_\_ No. of Hours\_\_\_\_\_

Percentage of time spent in:  
Diagnosis\_\_\_\_\_ Research\_\_\_\_\_ Group Therapy\_\_\_\_\_ Individual Therapy\_\_\_\_\_

Other (specify)\_\_\_\_\_

Name(s) of your direct supervisors\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please give current addresses if different from above, if possible)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No. of hours of supervision each month \_\_\_\_\_

Percentage of time spent on: Closed wards\_\_\_\_ Open wards\_\_\_\_ Out patient service\_\_\_\_

***IF YOU HAVE WORKED IN MORE THAN TWO HOSPITALS, USE AN EXTRA SHEET AND GIVE INFORMATION CALLED FOR ABOVE ALL HOSPITAL WORK.***

\*We may contact supervisors for information about your work. We will never communicate with your personal analyst(s).

**CLINIC WORK:** (Two years of full-time supervised clinic work - or equivalent in part-time work must have been completed before the date of application).

Name of Hospital \_\_\_\_\_

Address \_\_\_\_\_

Starting Date \_\_\_\_\_ Ending Date \_\_\_\_\_ No. of Hours \_\_\_\_\_

Percentage of time spent in:  
Diagnosis \_\_\_\_\_ Research \_\_\_\_\_ Group Therapy \_\_\_\_\_ Individual Therapy \_\_\_\_\_

Other (specify) \_\_\_\_\_

Name(s) of your direct supervisors\* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please give current addresses if different from above, if possible)

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No of hour of supervision each month\_\_\_\_\_

Types of patients chiefly worked with (i.e., adults, adolescents, children, psychotic, neurotics, addicts, etc.)\_\_\_\_\_

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Name of Hospital\_\_\_\_\_

Address\_\_\_\_\_

Starting Date\_\_\_\_\_ Ending Date\_\_\_\_\_ No. of Hours\_\_\_\_\_

Percentage of time spent in:  
Diagnosis\_\_\_\_\_ Research\_\_\_\_\_ Group Therapy\_\_\_\_\_ Individual Therapy\_\_\_\_\_

Other (specify)\_\_\_\_\_

Name(s) of your direct supervisors\*\_\_\_\_\_

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(Please give current addresses if different from above, if possible)

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No of hour of supervision each month\_\_\_\_\_

Types of patients chiefly worked with (i.e., adults, adolescents, children, psychotic, neurotics, addicts, etc.)\_\_\_\_\_

**IF YOU HAVE HAD EXPERIENCE IN MORE THAN TWO CLINICS, USE AN EXTRA SHEET AND GIVE INFORMATION CALLED FOR ABOVE ALL CLINICAL EXPERIENCE.**

\*We may contact supervisors for information about your work. We will never communicate with your personal analyst(s).

**RESEARCH WORK:** (Give a complete bibliography of your publications. If you have done any unpublished research, give a brief description of it. Use extra sheets if necessary)

**PERSONAL PSYCHOANALYSIS (or Psychotherapy):** Are you now in analysis\_\_\_\_\_

If YES, when did you begin? (Month & Year)\_\_\_\_\_

Name of your analyst (therapist)\*\_\_\_\_\_ Hrs. Per Week\_\_\_\_\_

With what school is your analyst affiliated?\_\_\_\_\_

List any previous analysts (therapists), affiliations, dates and frequency\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PRIVATE PRACTICE:** Are you doing any private therapy? Yes\_\_\_\_\_ No\_\_\_\_\_

If YES, when did you begin your private practice?\_\_\_\_\_

Approximately how many hours a week do you spend in private therapy?\_\_\_\_\_

Is your work supervised? Yes\_\_\_\_\_ No\_\_\_\_\_

List names, address and telephone numbers of your supervisor(s)\* and the dates between which they supervised your work.

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\_\_\_\_\_  
\_\_\_\_\_

**YOU MAY USE EXTRA SHEETS TO GIVE ANY ADDITIONAL INFORMATION WHICH YOU THINK MAY BE OF USE IN EVALUATING YOUR APPLICATION.**

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Signature

\*We may contact your supervisors for information about your work. We will never communicate with your personal analyst(s) or therapist(s)

Careful and through reading and understanding of all requirements is essential.

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PLEASE COMPLETE THE FOLLOWING:

- 1) Are there any judgments or settlements of malpractice actions against you?  
Yes\_\_\_\_No\_\_\_\_\_
- 2) Are there any pending malpractice actions? Yes\_\_\_\_No\_\_\_\_\_
- 3) Have there ever been, or are there now, any findings of professional misconduct against you? Yes\_\_\_\_ No\_\_\_\_
- 4) Have there ever been, or is there now, any information about you pertaining to:
  - a. The suspension, restriction, termination or curtailment of training, employment, association or professional privileges or license for any reason, or the denial of any certification of completion of any training for reasons related in any way to alleged mental impairment, incompetence, malpractice or any misconduct or impairment of patient safety and welfare? Yes\_\_\_\_No\_\_\_\_\_
  - b. The voluntary or involuntary resignation or withdrawal of any association or of any privileges including academic to avoid the imposition of disciplinary action? Yes\_\_\_\_No\_\_\_\_\_
  - c. Conviction of a crime? Yes\_\_\_\_No\_\_\_\_\_
- 5) Have you ever been sanctioned by, or are you now being reviewed by, any professional ethics board? Yes\_\_\_\_No\_\_\_\_\_
- 6A) If the answer to each of the above questions is "NO" please sign.

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(Signature)

6B) If the answer to any of these questions is "YES" please supply pertinent details on a separate page.

Please sign here to indicate your pledge to report any future instances of the above to the White Institute.

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(Signature)