



**Application Form
Couples Training Program**

Please type or print legibly and submit to the above address along with \$50 application fee.

Name: _____

Birthdate: _____

Home Address: _____

Phone: _____

Email: _____

Fax: _____

Business Address: _____

Phone: _____

Preferred mailing address: Work _____ Home _____

Current Malpractice Insurance Coverage: _____

EDUCATION:

| College/University | Major | # of Credits | Degree | Date of Graduation |
|--------------------|-------|--------------|--------|--------------------|
|--------------------|-------|--------------|--------|--------------------|

MENTAL HEALTH TRAINING (Internships, Residencies, Institutes, etc.):

| Institution | Course/Program | Dates | Supervisors |
|-------------|----------------|-------|-------------|
|-------------|----------------|-------|-------------|

CLINICAL EXPERIENCE (include training & professional experiences, listing most current first):

| Dates | Client Age Range | Treatment Modality | Setting Hosp./Clinic | Hours per Week | Supervision Type: Individ., Peer, Group (etc.) and Frequency |
|-------|------------------|--------------------|----------------------|----------------|--|
|-------|------------------|--------------------|----------------------|----------------|--|

OTHER PROFESSIONAL ACTIVITIES: (eg research, teaching, community work, writing, etc.)

PERSONAL PSYCHOTHERAPEUTIC AND/OR PSYCHOANALYTIC EXPERIENCE:

List below the type of psychotherapy (ind., family, couples, group), the therapist's name(s) and theoretical orientation(s), when, how often, and how long. Attach additional page if needed.

Mail to ICP&P (or call for more information):

4601 Connecticut Avenue, NW, Suite 8, Washington, DC 20008 Phone: (202) 686-9300 Fax: (202) 232-2565