



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

Institution	Course/Program	Dates	Supervisors
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**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
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**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