



THE NEW YORK INSTITUTE FOR PSYCHOTHERAPY TRAINING
In Infancy, Childhood and Adolescence
3701 Bedford Avenue
Brooklyn, New York 11229

**VERIFICATION OF CANDIDATE'S HOURS OF PERSONAL THERAPY
AND THERAPIST'S CREDENTIALS**

Dear Therapist,

_____ has applied to be a candidate in the New York Institute For Psychotherapy Training (NYIPT). Part of the requirement for the program is individual psychoanalytic psychotherapy. A candidate's therapist must be trained in a postgraduate institute in dynamically oriented therapy or psychoanalysis or the equivalent. The candidate must complete a minimum of 200 hours of dynamically oriented psychotherapy prior to graduation.

I would appreciate your completing the enclosed form and returning it to Dr. Carole Grand, Associate Director, 300 Mercer Street, New York, NY 10003 as soon as possible.

Thank you for your cooperation.

Sincerely,

Phyllis Cohen, Ph.D.
Executive co-Director, NYIPT



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CANDIDATE'S PERSONAL PSYCHOTHERAPIST INFORMATION

*This form is to be filled out by candidate's therapist and sent directly to
Dr. Carole Grand at 300 Mercer Street NY, NY 10003*

NAME OF CANDIDATE _____ DATE _____

All information that follows pertains to the professional training of candidate's therapist

NAME OF THERAPIST: _____

ADDRESS: _____

PHONE NO: _____

DEGREE EARNED _____ YEAR RECEIVED _____

NUMBER OF YEARS OF PRIVATE PRACTICE: _____

PSYCHOTHERAPY OR PSYCHOANALYTIC TRAINING RECEIVED AT:

NAME OF INSTITUTE: _____

INSTITUTE ADDRESS: _____

INSTITUTE PHONE NUMBER: _____

INSTITUTE DIRECTOR'S NAME: _____

SUPERVISOR'S NAMES

DATES OF SUPERVISION

SUPERVISOR'S NAMES	DATES OF SUPERVISION

CERTIFICATE GRANTED: (DATE) _____

[If equivalent training was received independent of a post-graduate institution, please list all courses and seminars (private or institute affiliated). Include specific titles, dates, and any supervision received. Please use an additional sheet for this information.]

All information that follows pertains to the candidates completion of individual therapy.

CANDIDATE'S NAME: _____

NO. OF HOURS SEEN TO DATE: _____

DATES OF TREATMENT: _____ TIMES SEEN PER WEEK: _____

TREATMENT COMPLETED? YES _____ NO _____

THERAPIST'S SIGNATURE

DATE