



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 CANDIDATE'S 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
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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 here 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**