PINE PSYCHOANALYTIC CENTER, INC.
22 GROSVENOR ROAD
NEEDHAM, MASSACHUSETTS 02492

TEL./FAX: 781-449-8365
OFFICE@PINEANALYSIS.ORG

PLEASE REPLY TO
P.O. Box 920762
NEEDHAM, MA 02492

APPLICATION FORM

NAME:

DATE OF BIRTH:

ADDRESS:

TELEPHONE
Office:
Home

E-MAIL ADDRESS

Name of your Training Director for degree in which you are licensed:

Name and Address of Training Program:

Year completed:

REFERENCES: At least two should be persons familiar with your clinical work. If you have been in a training a program during the past ten (10) years, one recommendation should be from the training director.

1. Name:
   Address:

2. Name:
   Address:

3. Name:
   Address:

4. Name:
   Address:

I agree to have PINE contact these references. I do ____ do not ____ waive the right to examine same.

____
Signature

1. Do you have a license by any state or national authority to practice your profession? If so, please indicate the name and location of the licensing authority, date of license, and license number.

For Questions 2-9, if you answer yes please attach an explanation:

2. Has your license to practice as designated above ever been revoked, suspended, or limited?

YES_____ NO_____

3. Have you withdrawn an application for a professional license or been denied a professional license for any reason?

YES_____ NO_____

4. Has any pending or new professional malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?

YES_____ NO_____

5. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? If yes, please provide details.

YES_____ NO_____

6. Are any formal disciplinary charges pending or has any disciplinary action (as defined by your professional Board regulations) been taken against you by any governmental authority, hospital, or other health care facility, or professional association (international, national, state or local)? If yes, please provide details.

YES_____ NO_____

7. FOR MDs or NPs ONLY: Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?

YES_____ NO_____

8. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice your profession?

YES_____ NO_____

9. Has any ethical complaint been made concerning you or has any investigation been opened concerning a potential ethical breach?

YES_____ NO_____

10. Have you engaged in the use of any chemical substances which in any way interfered with your ability to practice your profession?

YES_____ NO_____

11. Psychologists: Have you been certified in clinical psychology by ABEPP? Give the date and certificate number.

12. Social Workers: Do you hold the certificate of licensed independent clinical social worker issued by the Board of Social Workers? Give date and certificate number.

13. Psychiatrist: Have you been Board Certified in Psychiatry by the ABPN? Give date and certificate number.

Please submit a curriculum vitae along with this application.

Enclose $100 application fee.

PLEASE READ AND SIGN:

THE INFORMATION PROVIDED IN THIS APPLICATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE CONSENT TO THE INSTITUTE OF THE PINE PSYCHOANALYTIC CENTER TO MAKE INQUIRIES, WITH RESPECT TO MY APPLICATION, OF THE PERSONS LISTED AS REFERENCES. I AUTHORIZE THESE PERSONS TO RESPOND TO SUCH INQUIRIES. AS WELL, I GIVE CONSENT THAT PINE CAN RELEASE ALL OF THE INFORMATION THAT IS NECESSARY TO THE APPROPRIATE COMMITTEE OF THE AMERICAN PSYCHOANALYTIC ASSOCIATION.

_______________________________________ ______________________
Signature Date