Alliance
NORTHWEST ALLIANCE FOR PSYCHOANALYTIC STUDY
Alliance Community Psychotherapy Clinic (ACPC) (425) 656-9627

The Alliance Community Psychotherapy Clinic

Check appropriate box(es):

- ☐ Application for Psychoanalytic Psychotherapist
- ☐ Application for Psychoanalytic Psychotherapy Consultant

Name _____ Date _____

Professional Status (Circle one)

MA	MS	MSW	RN	ARNP	MD	PhD	MEd

other _____

Office Address _____

_____

Office Phone # _____ Alternate # _____

Email _____ Fax # _____

How is your practice covered when you are on vacation or temporarily unavailable?

Specialties

Primary Specialty _____

Secondary Specialty _____

Are you certified/licensed? ☐ Yes ☐ No

If "Yes" please indicate discipline and date _____ Date _____

_____

_____

Graduation date

Education and Training

Undergraduate College or University

Address

Post-graduate University

Address

☛ Please provide resume including current Professional/Continuing/Specialty Education

Briefly describe your own experience in psychotherapy as a patient.

Kind of therapy/modality _____

Number of hours per week _____

Duration of treatment _____

Other comments:

Practice Information

How long have you been in private practice? _____ ☐ months ☐ years

How long have you practiced at your current location? _____ ☐ months ☐ years

How long have you practiced in the State of WA? _____ ☐ months ☐ years

How long have you practiced psychotherapy in total? _____ ☐ months ☐ years

Is your practice full-time or part-time? ☐ Full-time ☐ Part-time

Circle one Solo Solo (Inc.) Group Group (Inc.)

Are you suffering from any disorder or illness (mental or physical) that limits or interferes with your ability to practice psychotherapy? ☐ No ☐ Yes

If "Yes", please explain:

Have you ever been convicted of a felony? ☐ No ☐ Yes
If "Yes", please explain:

Have you ever been found guilty or pleaded guilty to a misdemeanor directly related to your practice? ☐ No ☐ Yes
If "Yes", please explain:

☛ All participants in ACPC are required to provide a copy of malpractice insurance for your practice, a copy of your current license/registration, a current resume, and a completed Washington State Patrol Criminal Check form (enclosed). ACPC will process the criminal check at no expense to the applicant.

Please describe your current practice and your clinical experience working therapeutically with (1) adults; (2) families; and (3) children.

Please describe your experience as a consultant. (<u>For consultant applicants only</u>)

Personal References

Please provide the names of three people familiar with your work as a psychotherapist and your character. At least one must be someone who has supervised your work.

Name	***Telephone #***	***E-mail***	***Relationship***
1.			
2.			
3.			

I hereby affirm and attest that all statements, answers, and information contained in this application are true to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested will be sufficient cause for denial of this application and/or subsequent termination of the participating privileges granted upon the basis of the information contained herein.

Signature _____ Date_____

Please mail completed application, current resume, copy of malpractice insurance, copy of license/registration, and completed WSP Criminal Check form to:

ACPC
c/o NW Alliance
1416 NW 46th Ave Ste 105-527
Seattle 98107