

# Alliance

NORTHWEST ALLIANCE FOR PSYCHOANALYTIC STUDY

Alliance Community Psychotherapy Clinic (ACPC)  
1110-293rd NE, Carnation, WA 98014 (425) 656-9627

## The Alliance Community Psychotherapy Clinic

Check appropriate box(es):

- Application for Psychoanalytic Psychotherapist
- Application for Psychoanalytic Psychotherapy Consultant/Supervisor

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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_


**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?  
If "Yes", please explain:

 No Yes

Have you ever been found guilty or pleaded guilty  
to a misdemeanor directly related to your practice?  
If "Yes", please explain:

 No Yes

 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.**

**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.

| <u>Name</u> | <u>Telephone #</u> | <u>E-mail</u> | <u>Relationship</u> |
|-------------|--------------------|---------------|---------------------|
|-------------|--------------------|---------------|---------------------|

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  
Janet Allen  
1110 - 293rd NE  
Carnation, WA 98014