

**Center for Cognitive Therapy
 University of Pennsylvania Health System
 3535 Market Street, 2nd Floor
 Philadelphia, PA 19104-3309**

Name:	Date:
Address:	
Phone [H]:	Phone [W]:
Fax:	
Email:	
Date of Birth:	

(Upon acceptance into the program, you will also be asked to provide your Social Security number, so that you may obtain clearance to use the electronic medical records system.)

I am applying for: Cognitive Therapy Training Program/Therapy Training
 Cognitive Therapy Training Program/Diagnostic Interview
 Pre-doctoral Practicum/Diagnostic Interview Training
 Visiting Scholar

Present degree status: _____

Date you received, or expect, doctorate or terminal degree: _____

Type of program: Clinical Psychology Doctoral
 Counseling Psychology Predoctoral
 Social Work
 Other (specify) _____

If you are employed full-time, give title and setting:

The next three questions apply to Cognitive Therapy Training Program applicants only:

*Do you have, or will you qualify for, PA licensing by beginning of training here? YES NO

*In what other state are you licensed? _____

*Do you have malpractice insurance coverage? YES NO

How many patients have you treated using cognitive therapy? _____

What types of cases: Depression ____ Anxiety ____

Other – Personality Disorders _____

Were any of your clinical supervisors predominantly cognitive therapists? YES NO

If so, please name them:

If your present orientation is not predominantly cognitive, how would you characterize the conceptual model of therapy you work from? (Please name specific theorists.)

EXPOSURE TO COGNITIVE THERAPY

Please list the main seminars or conferences you have attended relevant to cognitive therapy:

List the main workshops, tapes, etc. relevant to cognitive therapy to which you have been exposed:

RESEARCH EXPERIENCE

Dissertation title (if applicable):

Current area of research interest (please be specific):

Approximate number of professional journal articles and book chapters published or in press:

OTHER INFORMATION

Please use additional pages to supply any additional information you feel would be helpful in evaluating your application.

Predoctoral Practicum/Diagnostic Interview Training: Please submit this application form, one letter of recommendation (sent via U.S. postal service, not via e-mail), a curriculum vita, official graduate school transcripts (not copies), a sample diagnostic report with a DSM-5 diagnosis, and a letter describing your professional interests and goals, particularly as they relate to our training program.

Cognitive Therapy Training Program/Therapy Training: Please submit this application form, a personal letter of interest in the program, a curriculum vita, one letter of recommendation (sent via the U.S. Postal Service, not via e-mail), a photocopy of professional license (if applicable), and a 50-minute audio or video recording of your clinical work with a patient. The recording can be a session with an actual patient or a role-played session. If the recording involves an actual patient, do not identify him or her by name, and obtain signed consent from the patient to submit the recording.

Cognitive Therapy Training Program/Diagnostic Interview Training: Please submit this application form, a personal letter of interest in the program, a curriculum vita, one letter of recommendation (sent via the U.S. Postal Service, not via e-mail), a photocopy of professional license (if applicable), and a sample assessment report with a DSM-5 diagnosis (please omit or obscure identifying patient information).

We are an equal opportunity, affirmative action employer.