

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

Name \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone [H] \_\_\_\_\_

Phone [W] \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

---

---

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 Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

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 five AXIS 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 five AXIS diagnosis (please omit or obscure identifying patient information).

*We are an equal opportunity, affirmative action employer.*