

**BOSTON GRADUATE SCHOOL OF PSYCHOANALYSIS
APPLICATION TO GRADUATE
CLINICAL DOCTORAL PROGRAM (PSYA. D.)**

Date _____

Name _____

Enrolled (date) _____ Completed Coursework (date) _____

1. Academic Background

Degree/Major _____ Institution _____ Year of Graduation _____

Degree/Major _____ Institution _____ Year of Graduation _____

Degree/Major _____ Institution _____ Year of Graduation _____

Master's Thesis or equivalent requirement met? Yes _____ Date _____ No _____

2. Training Analysis Information

A. Analyst _____ # of sessions _____

Date Started _____ through _____

B. Analyst _____ # of sessions _____

Date Started _____ through _____

C. Analyst _____ # of sessions _____

Date Started _____ through _____

Advisor Use Section verified by _____ Date _____
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3. Group Analysis

A. Analyst _____ # of sessions _____

Date Started _____ through _____

B. Analyst _____ # of sessions _____

Date Started _____ through _____

C. Analyst _____ # of sessions _____

Date Started _____ through _____

Advisor Use Section verified by _____ Date _____
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4. Core Curriculum: List only courses passed

Maturation Sequence: (* required)

*PT/CP 141 semester _____

Other /semester _____

*PT/CP 142 semester _____

Other /semester _____

Other /semester _____

Other /semester _____

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Theory Sequence: (*required)

*PT 151a semester _____ *PT 151b semester _____
PT 152 semester _____ *PT 154 semester _____
*PT 155 semester _____ *PT 156 semester _____
*PT 157/158 semester _____ *PT 159 semester _____
*PT 160 semester _____ Other/semester _____
Other/semester _____

History of Psychoanalytic Theory Sequence (* required)

*PT 161 semester _____ * PT 162 semester _____
PT 163 semester _____ Other/semester _____
Other/semester _____

Research Sequence

*PT 171 semester _____ * PT 172 semester _____
*PT 173 semester _____ PT 283 semester _____
PT 284 semester _____ * PT 285 semester _____
PT 286 semester _____ Directed Research (527/528/529) _____
Directed Research (527/528/529) _____ Other/semester _____
Other/semester _____

Other Courses

Group Analysis CP/PT 150 semester _____
*Ethics PT 187 semester _____
Human Diversity PT 104 semester _____

5. Clinical Level A Field work

Placement _____
From _____ To _____

FW Supervisor(s) _____
Completion of FW letter signed by _____

Clinical Courses:

PT 181 semester _____ PT 184 semester _____
PT 185 semester _____ PT 185 semester _____
PT 185 semester _____ PT 186 semester _____
Other _____ Other _____

FW Coordinator Use Section verified by _____ Date _____

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PT 111 Field work Supervision:

Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____

6. Therapy Center History

Date Started at Therapy Center _____ Current Fellow _____

Previous Fellow(s) _____

Complete a case history of your referred cases and attach it to this application. (See attached *Form 17A*)

Clinical Practice Seminars:

PT 2610: # of semesters _____

PT 2611: # of semesters _____

PT 2612: # of semesters _____

Other: _____

PT 211 T/S Supervision:

Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____

PT 311 Individual Supervision:

Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____
Semester _____	Supervisor _____	# Sessions _____

Advisor signature on completion of above listed

Course work and clinical experience: _____

Signature

Date

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7. Control Analysis

PT 411 Control Analyst _____ # Sessions _____
Name of Case Presented _____ Date Began _____

Frequency _____ Date Completed _____
Signed Letter: Yes _____ No _____

8: Clinical Case Presentation I (after 25 control hours) Date: _____

Recommendations:

9. Dissertation Project

Title: _____

Approved: Yes ___ Date _____ No ___ Date _____

Committee Member #1 _____ Approved _____
Committee Member #2 _____ Approved _____
Committee Member #3 _____ Approved _____

Doctoral Defense: Date _____ Disposition: _____

Recommendations _____

Approved by _____

Dissertation Defense Approved by (Committee Members):

Name _____ Title _____ Date _____

Name _____ Title _____ Date _____

Name _____ Title _____ Date _____

Control Analyst Use Section verified by _____ Date _____
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Fellow Use Section verified by _____ Date _____

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Student Name _____

Final Clinical Presentation (if separate) Date _____

Disposition: _____

Approved by _____

Fiscal Department Section

1.) All tuition, fees and other outstanding debts have been paid. _____ Yes _____ No

Director of Fiscal Affairs Signature: _____ *Date:* _____

Financial Aid Department Section

1.) Student Loan Exit Counseling Session has been completed. _____ Yes _____ Not Applicable

Director of Financial Aid Signature: _____ *Date:* _____

Library Section

1.) All books, journals are returned. _____ Yes _____ No

2.) All fees paid. _____ Yes _____ No

Librarian Signature: _____ *Date:* _____

Registrar's Section

1.) Documentation of completion of dissertation is in the student's file. _____ Yes _____ No

2.) Three hard bound copies of dissertation received. _____ Yes _____ No

3.) Graduation Fee Paid. _____ Yes _____ No (Date: _____)

Registrar's Signature: _____ *Date:* _____

Graduation Application Approved, Dean's Signature: _____
Signature Date

Board's Approval:

Graduation Date _____

Signature _____ Date _____