



General Information

Name _____

Home Address _____

Home Phone _____ Work Phone _____

E-mail address _____

How did you learn about our Postgraduate Training Program? _____

I am available to start: June September Either

Education

Degree _____ Year Completed _____ Institution _____

Degree _____ Year Completed _____ Institution _____

Degree _____ Year Completed _____ Institution _____

Are you licensed by the State of Illinois? No Yes Type of License _____ License number _____

Professional Therapy Training: list internships, certificate programs, supervision, intensive trainings, etc.

Year	Organization / School	Title of Training

Clinical Experience

Years of post-masters clinical experience: _____ Years of related experience (may be volunteer): _____

Please check significant clinical experience (i.e.: more than one or two clients):

- Experience working with women/women's issues? No Yes Experience with individuals? No Yes
- Experience working with trauma? No Yes Experience with couples? No Yes
- Experience with adults? No Yes Experience with families? No Yes
- Experience with adolescents? No Yes Experience with groups? No Yes
- Experience with children? No Yes Experience with presentations? No Yes

Current employment: _____

Title _____ Length of employment _____

