**General Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | | Credentials |  | | |
| Home Address |  | | | City |  | | | | | Zip |  |
| Cell Phone: |  | Work Phone | | | |  | | | | | |
| Email (personal) |  | | Email (work) | | | |  | | | | |
| Employer Name |  | | | | | | | | | | |
| Employer Address |  | | | City |  | | | | | Zip |  |

**Education**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Degree |  | | | Yr. Completed |  | | | Institution |  | | |
| Degree |  | | | Yr. Completed |  | | | Institution |  | | |
| Degree |  | | | Yr. Completed |  | | | Institution |  | | |
| Are you licensed by the State of Illinois? | | | Yes No | | Type of License |  | | | | License Number |  |
| Professional Therapy Training: List internships, certificate programs, supervision, intensive trainings, etc.: | | | | | | | | | | | |
| Year | | Organization/School | | | | | Title of Training | | | | |
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|  | |  | | | | |  | | | | |

**Clinical Experience**

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| --- | --- | --- | --- | --- | --- | --- |
| 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? | | Yes No | | Experience with individuals? | Yes No | |
| Experience working with trauma? | | Yes No | | Experience with couples? | Yes No | |
| Experience with adults? | | Yes No | | Experience with families? | Yes No | |
| Experience with adolescents? | | Yes No | | Experience with groups? | Yes No | |
| Experience with children? | | Yes No | | Experience with presentations? | Yes No | |
|  | |  | |  |  | |

**References**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please list three supervisors or colleagues who could speak to us about your clinical work: | | | | | | |
|  | Name |  | Position |  | Phone | |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Please return this form along with a copy of your resume/CV and a cover letter indicating the reasons you would be a good fit for this program to [**achandler**@**womencarecounseling.com**](mailto:achandler@womencarecounseling.com) or

**Womencare Counseling Center**

**Attn: Postgraduate Fellowship Program**

**1740 Ridge Avenue, Suite 201**

**Evanston, IL 60201**

I certify all the above information is accurate and true

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**Applications must be received by March 15.**

What would you hope to do after completing this training program?

How did you hear about this fellowship program?

What concerns or questions do you have about participating in this intensive program?

Please list a few goals you would have for your learning experience with us (please be as specific as possible)?

1.

2.

3.

4.

5.

What interests you about the Postgraduate Fellowship Program?