



WILLIAM ALANSON WHITE  
I · N · S · T · I · T · U · T · E  
of Psychiatry, Psychoanalysis & Psychology

Dear Colleague:

We welcome your interest in the Low Cost Psychotherapy Supervision Service. After completion of this application you will be referred to a supervisor who is a faculty member and supervisor at the William Alanson White Institute. Most referrals are made within two weeks. While assignments are made primarily on the basis of availability, we will make every effort to meet your particular interests and needs as indicated in the attached application. The procedures of the service are as follows:

**A non-refundable \$100 fee must be submitted with the application.**

**The fee for ongoing supervision will be \$90 per session.**

Scheduling will be arranged between you and your assigned supervisor. The supervisory arrangements shall remain in effect for 40 sessions. At the end of that time you may negotiate a new arrangement with your supervisor or you may reapply to the Service for a new referral.

Supervisors will not be responsible for insurance coverage, reports, or licensure requirements etc. Applicants must provide their own clinical work for discussion. Participation in this service may not be used to fulfill the requirements of educational programs at the White Institute or elsewhere, and participants may not represent themselves as trainees of the White Institute or any of its programs.

It is understood that in signing this application you are asserting that you are licensed to practice psychotherapy or psychoanalysis in the state in which you practice.

***For this application to be processed you must include documentation of your professional liability insurance and current New York State license registration. Copies of relevant documents will be sufficient.***

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Application to Low Cost Psychotherapy Supervision Service

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

Address: \_\_\_\_\_

\_\_\_\_\_

Degree: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

(Please specify where you are most easily reached during the day and when you are available)

**Please describe your most recent (or highest level) training and educational experiences (include dates)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To participate in the supervision service you must demonstrate that you are licensed or otherwise legally permitted to practice psychotherapy. Please describe your credentials and when they were obtained.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your current work situation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total Number of years of clinical experience (all settings): \_\_\_\_\_

Are you in private practice? \_\_\_\_\_ For how many years? \_\_\_\_\_

Please describe your practice and caseload.

---

---

---

Do you see patients more than 1X per week: \_\_\_\_\_

Are you requesting supervision on:

*Individuals*       *Couples*       *Groups*  
 *Adults*       *Children*       *Adolescents*       *Seniors*

Are you requesting supervision for patients predominately dealing with/or having a history of:

*Anxiety / Anxiety Disorders*       *Depression*       *Mood disorders*  
 *Bipolar Disorder*       *Adjustment Disorders*       *Character Neurose:*  
 *Personality Disorders*       *Suicidality*       *Prior Hospitalizatio*  
 *Serious Mental Illness*       *Addiction issues*       *Eating Disorders*  
 *Impulse Control Disorders*       *Antisocial Behavior*       *PTSD*  
 *History of Sexual Abuse*       *Stage of Life issues*  
 *Other*

---

If your clinical caseload includes children and adolescents check the predominant symptomatology.

*Autistic Spectrum*       *Oppositional/Defiant*       *Eating Disorders*  
 *Substance Abuse*       *Mood/Anxiety*

The following questions concern your preferences and special needs. Please answer YES or No and circle any area which is of primary importance to you.

Do you have a preference concerning gender?       Male       Female

Location (\*=Manhattan):

Uptown\*       Downtown\*       Eastside\*       Westside\*  
 Queens       Brooklyn       Bronx       Long Island  
 Westchester       Rockland       New Jersey       Connecticut  
 Other: \_\_\_\_\_

---

What hours are you available? Please write in all that apply.

Monday: \_\_\_\_\_  
Tuesday: \_\_\_\_\_  
Wednesday: \_\_\_\_\_  
Thursday: \_\_\_\_\_  
Friday: \_\_\_\_\_  
Saturday: \_\_\_\_\_

What would you like to emphasize in the supervision? For example:

*Differential Diagnosis*

\_\_\_ *Beginning Treatment*

*The Difficult Patient*

\_\_\_ *Crisis or Impasse*

*Enactments*

\_\_\_ *Confrontation*

*Transference-Countertransference*

*Other:* \_\_\_\_\_

Describe your ideal supervisor

Do you have any special needs or requirements?

Please send a copy of this application along with the required documentation and application fee to:

**Diane Goldkopf, PhD, Director of LCPSS  
c/o Meghana Giridhar  
William Alanson White Institute  
20 W. 74th Street  
New York, NY 10023**

Or, email the application & required documents to: [m.giridhar@wawhite.org](mailto:m.giridhar@wawhite.org)

**Please also attach an up-to-date resume with your application.**

To pay the application fee by a method other than check,  
please contact Faride Garcia at: [f.garcia@wawhite.org](mailto:f.garcia@wawhite.org)