

**THE NEW JERSEY INSTITUTE FOR TRAINING IN PSYCHOANALYSIS**

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**REGISTRATION FACT SHEET--CHILD & ADOLESCENT PROGRAM**

**\*\*PLEASE ANSWER ALL QUESTIONS AND RETURN WITH REGISTRATION\*\***

NAME: \_\_\_\_\_ HIGHEST DEGREE \_\_\_\_\_

YEAR OF CANDIDACY: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_

POSITION AND DUTIES: \_\_\_\_\_

ARE YOU AFFILIATED WITH THE PSYCHOANALYTIC CLINIC? YES ( ) NO ( )

IF NO, DO YOU PLAN TO AFFILIATE? YES ( ) WHEN \_\_\_\_\_ NO ( )

CURRENT SUPERVISOR: \_\_\_\_\_ DATE BEGAN: \_\_\_\_\_

PREVIOUS SUPERVISOR: \_\_\_\_\_ DATES \_\_\_\_\_

IF CURRENTLY IN AN EXTERNSHIP/INTERNSHIP PROGRAM, GIVE NAME OF AGENCY,  
TYPES OF PATIENTS SEEN, NUMBER OF HOURS PER WEEK, ETC.:

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

HOW MANY PATIENTS ARE YOU SEEING PER WEEK?

CHILDREN: \_\_\_\_\_ AGES: \_\_\_\_\_

ADOLESCENTS: \_\_\_\_\_ AGES: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE \_\_\_\_\_