

Citrus Health Network, Inc.
Post-Doctoral Residency Program Application

Please complete each section by providing as much information as possible. This will better assist in evaluating your application.

SECTION I: DEMOGRAPHIC AND EDUCATIONAL INFORMATION

A. DEMOGRAPHIC INFORMATION

First Name: _____ Last Name: _____

Other Names Used (transcripts): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ (Work): _____

Phone (Cell): _____ Fax: _____

Email: _____

What is your country of citizenship? U.S. Canada Other specify: _____

Non-Citizen visa status: _____ Is this visa current and valid? Yes No

Does this visa allow you to work? Yes No Are you a veteran? Yes No

B. EDUCATION:

1. Doctoral Program Information:

Graduate Program Name: _____

Department Name: _____

University Name: _____

Street Address: _____

City, State, Zip: _____

2. What is the designated subfield of your doctorate in Psychology? (Check one)

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavioral & Cognitive | <input type="checkbox"/> Clinical Child | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Clinical Neuropsychology | <input type="checkbox"/> Clinical Health | <input type="checkbox"/> Clinical |
| <input type="checkbox"/> Forensic | <input type="checkbox"/> Family | <input type="checkbox"/> Psychoanalysis |
| <input type="checkbox"/> School | <input type="checkbox"/> Professional Geropsychology | <input type="checkbox"/> Industrial-Organizational |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Combined (specify, if combined: _____) | |

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3. What is your primary theoretical orientation? Please mark up to 3 in rank order.

- Behavioral Biological Cognitive Behavioral Integrative
 Interpersonal Systems Humanistic/Existential
 Psychodynamic/Psychoanalytic Other: _____

4. What degree do you have or are you seeking?

- Ph. D. Psy.D. Ed.D. Ph.D/J.D. Other: _____

5. Training Director Information:

Training Director Name: _____

Training Director Email: _____

University/School Phone#: _____ Fax#: _____

6. What is the Accreditation Status of your doctoral training program?

- APA-Accredited APA-Accredited, probation APA-Accredited, inactive
 Not APA-Accredited

7. What was your Department's Training Model?

- Clinical Scientist Practitioner-Scholar Scientist-Practitioner
 Practitioner Other – specify: _____

8. When did you complete (or do you expect to complete) your doctoral coursework, including dissertation and internship hours?

_____ (mm/yyyy)

Comments:

9. What was your dissertation/research title or topic?

10. What type of research was involved in your dissertation/research?

- Critical literature review/theoretical Use of existing database
 Original data collection Other – specify: _____

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11. Dissertation/doctoral research advisor contact information?

Dissertation/Doctoral Advisor's Name: _____

E-Mail: _____ Phone #: _____

12. Please complete the following table listing each undergraduate and graduate school attended: (list in chronological order)

UNDERGRADUATE & GRADUATE SCHOOLS ATTENDED				
School/University	Major	Degrees Earned	Dates Attended	GPA

13. Involvement in Professional Organizations: Please list the membership(s) you hold in professional organizations. Also note the activities in which you have been involved in these organizations; i.e., APA, State Psychological Association (student representative on a committee), etc:

14. Licensure/Certification: Some applicants may hold another licensed or certified at the any level. If you have, please list any current and valid licenses or certifications in mental health fields.

License:

Jurisdiction:

License:

Jurisdiction:

15. Please list any honors received:

16. Research Publications: Please list, in APA format, any publications for which you hold authorship:

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17. Please list names, addresses, phone numbers, and e-mail addresses of individuals who will be forwarding letters of recommendation: Please note that CHN requires 2 letters of recommendation from a professional source sent directly to the training director.

Recommendation #1:

Name: _____
Street Address: _____ City: _____ State: _____
Phone: _____
Email Address: _____

Recommendation #2:

Name: _____
Street Address: _____ City: _____ State: _____
Phone: _____
Email Address: _____

SECTION 2: ESSAYS

Instructions: Please answer each question in 500 words or less, in the space below each question.

1. Please provide an autobiographical statement. (There is no “correct” format for this question. Answer the question as if someone had asked you “tell me something about yourself.”)

2. Please describe your theoretical orientation and how this influences your approach to case conceptualization and intervention. You must de-identified cases if you choose to use case material to illustrate your points.

3. Give a summary of your internship experience and state how you envision our Residency site meeting your training goals and interests?

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SECTION 3: INTERVENTION AND ASSESSMENT EXPERIENCE

1. How much experience do you have with different types of psychological interventions and assessments?

Please report actual clock hours in direct service to clients/patients. Hours should not be counted in more than one category. Experiences involving gathering information about the client/patient, but not in the actual presence of the client/patient, should instead be recorded under item 4, below (“Support Activities”). For the “Total hours face-to-face” columns, count each hour of a group, family, or couples session as one practicum hour. For example, a two-hour group session with 12 adults is counted as two hours. For the “# of different...” columns, count a couple, family, or group as one (1) unit. For example; meeting with a group of 12 adults over a ten-week period for two hours per week counts as 20 hours and one (1) group. Groups may be closed or open membership; but, in either case, count the group as one group.

***Remember that hours accrued while earning a master’s degree as part of a doctoral program should be counted as doctoral practicum hours.**

	HOURS			
a. Individual Therapy	None	1-5 hours	5-10 hours	10+ hours
1) Older Adults (65+)				
2) Adults (18-64)				
3) Adolescents (13-17)				
4) School-Age (6-12)				
5) Pre-School Age (3-5)				
6) Infants/Toddlers (0-2)				
b. Group Counseling	None	1-5 hours	5-10 hours	10+ hours
1) Adults				
2) Adolescents (13-17)				
3) Children (12 & under)				
c. Family Therapy	None	1-5 hours	5-10 hours	10+ hours
d. Couples Therapy	None	1-5 hours	5-10 hours	10+ hours

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e. School Counseling Interventions	None	1-5 hours	5-10 hours	10+ hours
1) Consultation				
2) Direct Intervention				
3) Other: N/A				
f. Other Psychological Interventions	None	1-5 hours	5-10 hours	10+ hours
1) Medical/Health-Related Interventions				
2) Intake Interview/ Structured Interview				
3) Substance Abuse Interventions				
4) Consultation				
5) Forensic				
6) Other Intervention (e.g., milieu therapy, treatment planning with the patient present.)				
Please describe the nature of the experience in f-6:				

g. Psychological Assessment Experience: (Check all that apply)

PSYCHOLOGICAL ASSESSMENT EXPERIENCE		
	DOCTORAL*	TERMINAL MASTERS*
1) Psychodiagnostic test administration (include symptom assessment, projectives, personality, objective measures, achievement, intelligence, and career assessment), and providing feedback to clients/patients.		
2) Neuropsychological Assessment (include intellectual assessment in this category only when it was administered in the context of neuropsychological assessment involving evaluation of multiple cognitive, sensory and motor functions).		
3) Other (specify):		

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h. Other Psychological Experience with Students and/or Organizations: (Check all that apply)

OTHER PSYCHOLOGICAL EXPERIENCE WITH STUDENTS AND/OR ORGANIZATIONS		
	DOCTORAL*	TERMINAL MASTERS*
1) Supervision of other students performing intervention and assessment activities		
2) Program Development/Outreach Programming		
3) Outcome Assessment of programs or projects		
4) Systems Intervention/Organizational Consultation/Performance Improvement		
5) Other (specify):		

2. SUPERVISION RECEIVED – How much time have you spent in supervision?

Supervision is divided into one-to-one, group, and peer supervision/consultation. Supervision provided to less advanced students should be counted in item 1i-l above.

Item 2a: Hours are defined as regularly scheduled, face-to-face individual supervision with specific intent of overseeing the psychological services rendered by the student.

Items 2b and 2c: The hours recorded in the group supervision category should be actual hours of group focus on specific cases. Many excellent practicum courses incorporate both didactic and experiential components in the course activity. **While the didactic portion is excellent training, it should not be recorded as a supervision activity; it should instead be included as a support activity in Item 4 (“Support Activities”) below.** This may necessitate breaking the hours spent in a practicum course into intervention, supervision, and didactic activities by actual course hours. For example, if you present on the “Psychosocial Issues of HIV Infection” using examples of cases, it is a didactic activity. Similarly, Grand Rounds that consists of in-service education on specific topics would not be considered supervision for the purposes of documenting practicum hours, but would be considered a support activity.

	DOCTORAL* Total hours face-to-face	TERMINAL MASTERS* Total hours face-to-face
a. Hours spent in one-on-one, face-to-face supervision:		
b. Hours spent in group supervision:		
c. Hours of peer supervision/consultation and case discussion on specific cases:		
Total Supervision Hours (add 2a., 2b., 2c.):		

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3. INFORMATION ABOUT YOUR TRAINING EXPERIENCES

a. TREATMENT SETTINGS - How many hours have you spent in each of the following treatment settings? Please indicate the estimated total number of hours spent in each of the following treatment settings.

	None	1-5 hours	5-10 hours	10+ hours
Child Guidance Clinic				
Community Mental Health Center				
Department Clinic (psychology clinic run by a department or school)				
Forensic/Justice setting (e.g., jail, prison)				
Medical Clinic/Hospital				
Inpatient Psychiatric Hospital				
Outpatient Psychiatric Clinic/Hospital				
University				
Counseling Center/ Student Mental Health Center				
Schools				
VA Medical Center				
Other (specify):				

b. What types of groups have you led or co-led? Please describe, include the type of group, approximate duration and average number of clients at each group session.:

c. Do you have experience with Managed Care Providers in a professional therapy/ counseling/ assessment capacity? Yes No

d. Have you audiotaped, videotaped, or made digital recordings of clients/patients and reviewed these with your clinical supervisor?

Audio tape review: Yes No

Videotape/digital recording review: Yes No

Live/direct observation by supervisor: Yes No

e. In which languages other than English (including American Sign Language) are you FLUENT enough to conduct therapy?

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7. Please describe in essay format, your experience and training in work with diverse populations. Your discussion should display explicitly the manner in which multicultural/diversity issues influence your clinical practice and case conceptualization.

Please indicate your experience for each of the following diverse populations.

RACE/ETHNICITY		
	Intervention	Assessment
African-American/Black/African Origin		
Asian-American/Asian Origin/Pacific Islander		
Latino-a/Hispanic		
American Indian/Alaska Native/Aboriginal Canadian		
European Origin/White		
Bi-racial/Multi-racial		
Other (specify):		

Please indicate your experience for each of the following diverse populations.

SEXUAL ORIENTATION		
	Intervention	Assessment
Heterosexual		
Homosexual		
Bisexual		
Other (specify:)		

Please indicate your experience for each of the following diverse populations.

DISABILITIES		
	Intervention	Assessment
Physical/Orthopedic Disability		
Blind/Visually Impaired		
Deaf/ Hard of Hearing		
Learning/Cognitive Disability		
Developmental Disability (Including Mental Retardation and Autism)		
Serious Mental Illness		
Other (specify:)		

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Please indicate your experience for each of the following diverse populations.

GENDER		
	Intervention	Assessment
Male		
Female		
Transgendered		

7. CLINICAL WORK EXPERIENCES – What other clinical experiences have you had?

8. TEACHING EXPERIENCES – What is your teaching experience? Include any undergraduate or graduate courses you have taught.

SECTION 4: TEST ADMINISTRATION

List all the instruments you have had experience administering: