

DATE: _____

APPLICANT INFORMATION

Name: _____ Address 1: _____

Phone: _____ Address 2: _____

Email: _____ Languages Spoken in Session: _____

CLINICAL EXPERIENCE

Please indicate areas in which you have clinical experience:

TREATMENT CONTEXT	Independent direct care	Co-treat	Shadow	Observe (via one-way mirror or CCTV)	Other: _____
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate modalities and populations with which you have clinical experience:

CLINICAL STRUCTURE	Child	Adolescent	Adult	Caseload	Session frequency	Total face-to-face clinical hours
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
In-home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

SIGNATURE

Applicant Signature

Date

I do hereby certify that all statements made by me in this application are true and correct to the best of my knowledge.



APPLICATION CHECKLIST

Your application must also include the following documents:

- Brief (1-3 page) Personal Statement (please include professional interests, reasons for applying to *this* Fellowship, what you hope to gain from Fellowship, what you can contribute to Fellowship, and how this relates to your long-term career goals)**
- Curriculum vitae or resume**
- Official transcript (graduate education)**
- Three (3) letters of recommendation**
- Clinical narrative report (de-identified clinical report that includes presenting problem, history, current symptoms, diagnostic formulation, treatment goals, and intervention approaches)**

ALL COMPONENTS OF APPLICATION MUST BE SUBMITTED AS SINGLE, COMPLETE APPLICATION PACKAGE.

APPLICATIONS ARE DUE (MUST BE POSTMARKED) BY JANUARY 5, 2013.

LATE OR INCOMPLETE APPLICATION PACKAGES WILL NOT BE ACCEPTED.

Please send your complete application package to:

**Anne Santello, Senior Administrative Assistant
Yale Child Study Center
98 York Street
New Haven, CT 06511**

