

# AUSTEN RIGGS CENTER

**All completed materials should be mailed to:**  
 Austen Riggs Center, c/o Kathie Young, 25 Main Street PO Box 962, Stockbridge, MA 01262  
 or Kathleen.Young@AustenRiggs.net

## Virtual Elective in Psychodynamic Psychiatry Application

Date: 10/18/2021-10-29/2021

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip Code

Mobile # \_\_\_\_\_ Medical School \_\_\_\_\_  
 Other Contact # \_\_\_\_\_ Address: \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Best time to call you \_\_\_\_\_ School Phone # \_\_\_\_\_  
 Birth Date (mm/dd/yyyy) \_\_\_\_\_ School Fax # \_\_\_\_\_

### Educational Background: Post Graduate, Graduate, and Undergraduate

Starting with your most recent training/school, provide the following information:

Training/School (Include City and State)	Years Completed	Completed	Area of Specialization Major/Minor
		Degree _____ Certificate _____ Other _____	
		Degree _____ Certificate _____ Other _____	
		Degree _____ Certificate _____ Other _____	

List the name and telephone number of the person most immediately responsible for your psychiatric education.

Name	Title	Relationship to You	Telephone

Emergency contact information

Name	Relationship to You	Contact #	Alternative Contact

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## Elective in Psychodynamic Psychiatry Application, cont.

Name \_\_\_\_\_  
Last First Middle

### The following documentation is necessary for processing your application:

- \_\_\_\_\_ Completed application
- \_\_\_\_\_ Current curriculum vitae
- \_\_\_\_\_ Verification of HIPAA training

### All completed materials should be mailed to:

Austen Riggs Center, c/o Human Resources, 25 Main Street PO Box 962, Stockbridge, MA 01262

### Applicant Statement

I certify that all information I have provided is true, complete and correct.

I expressly authorize, without reservation, the Austen Riggs Center to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or interview. I hereby release such individuals from any and all liability for damages arising from furnishing the requested information.

I understand that this elective is part of my educational training and that I shall not be considered an employee of the Austen Riggs Center if I shall be selected to participate in the elective.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) eliminate me from further consideration, or (ii) may result in my immediate discharge from the elective, whenever it is discovered.

I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### To Be Completed by Student's Dean's Office or Authorized School Official

<p>The above student/trainee is currently enrolled and is in good standing at this institution.</p> <p>The above student has completed a core clinical clerkship in psychiatry.</p> <p>The student/trainee completed HIPAA Training. Date ____/____/____</p> <p>The student/trainee is authorized to take this elective through this office.</p> <p>Name: _____ Date: ____/____/____</p> <p>Title: _____ Signature: _____</p> <p>(School Seal)</p>
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