

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

Elective in Psychodynamic Psychiatry Application

Requested Dates: First Choice _____ Second Choice _____ Third Choice _____

Name _____
Last First M.I. Preferred pronouns (optional)

Address _____
Street City State Zip Code

Training Level Medical Student Resident _____ School/Program _____

Phone # _____ Address: _____

E-mail _____

Best time to call you _____ Phone # _____

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 _____	

Skills and Qualifications: Summarize any additional clinical, academic, research, or other experiences that you feel are relevant to your learning role in psychodynamic psychiatry – you also may include a description of verifiable volunteer work performed.

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

Name	Title	Relationship to You	Telephone

Emergency Contact

Name	Relationship to You	Telephone	Alt 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
- _____ Proof of up-to-date PPD test OR Recent chest X-Ray documentation
- _____ Proof of COVID-19 vaccination or medical exemption
- _____ Current curriculum vitae
- _____ Personal statement regarding your interest in the elective (500 words or less)

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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

The above student/trainee is currently enrolled and is in good standing at this institution.

The above student has completed a core clinical clerkship in psychiatry.

The student does have personal health insurance.

Malpractice insurance is in effect while the student is away from his/her school or training program.

(Copy of malpractice certificate) or \$_____ per occurrence / \$_____ aggregate.

The student/trainee completed HIPAA Training. Date ____/____/____.

The student/trainee has completed universal precautions (OSHA) program. Date ____/____/____.

The student/trainee is authorized to take this elective through this office.

Name: _____ Date: ____/____/____

Title: _____ Signature _____

(School Seal)