



Association for  
Psychoanalytic  
Psychotherapy in the  
National Health Service

# Membership application form

Title \_\_\_\_\_ First name \_\_\_\_\_ Surname \_\_\_\_\_

Address (work/home) \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Professional / Occupational Title (please tick)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Psychoanalytic Psychotherapist      | <input type="checkbox"/> Psychodynamic Psychotherapist | <input type="checkbox"/> Counsellor           |
| <input type="checkbox"/> Mental Health Nurse                 | <input type="checkbox"/> Psychiatrist                  | <input type="checkbox"/> Arts Psychotherapist |
| <input type="checkbox"/> Clinical / Counselling Psychologist | <input type="checkbox"/> Other (please specify) _____  |   |

**Professional Affiliation (please tick)**

- |                               |   |                                  |
|-------------------------------|---|----------------------------------|
| <input type="checkbox"/> BPC  | <input type="checkbox"/> UKCP                         | <input type="checkbox"/> BACP    |
| <input type="checkbox"/> NMC  | <input type="checkbox"/> BPS                          | <input type="checkbox"/> RCPsych |
| <input type="checkbox"/> RCGP | <input type="checkbox"/> Other (please specify) _____ |                                  |

**Employment Description** (Please describe the Service / department etc. where you work: e.g. Location [local authority]; Commissioner; Provider; approximate size [staff number]; patient population; treatments offered etc.)

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

**Direct Contact with Patients** (Please tell us how many hours in an average week you spend in direct contact with NHS-funded patients) \_\_\_\_\_

Please describe other main activities \_\_\_\_\_

\_\_\_\_\_

**Training in Psychoanalytic Psychotherapy / Psychodynamic Counselling**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> BPC accredited | <input type="checkbox"/> UKCP accredited | <input type="checkbox"/> BACP accredited |
| Qualification:                          | Qualification:                           | Qualification:                           |
| Training provider:                      | Training provider:                       | Training provider:                       |

Other (please specify) \_\_\_\_\_

Continues overleaf

