Application

2023-24 International Training & Certification Program in Schema Therapy

The Cognitive Therapy Center of NJ
Schema Therapy Institutes of NJ-NYC

All applications and supporting materials for the 2023-24 program must be received by August 1, 2023.
Late applications will be considered if there are openings available.

You may add additional pages to this application to clarify or elaborate on any of the questions below, if you need more space.

Name____

Today’s Date____________________ Gender: Male □ Female □

Current Institution/Organization and Title (if any):

____

____

Work Address: ____

City/State/Postal Code: ____________________________________

Country: ____

Home Address: _______________________________________

City/State/Postal Code: ____________________________________

Country: ____

*Work Telephone: ______________________________________

*Home Telephone: ______________________________________

*Mobile Phone: ______________________ *Fax: __________________

Primary E-Mail (required): __________________________________

Alternate E-Mail address (optional): ____________________________

Website (optional):_______________________________________

**Be sure to include your country code, city code, and/or area code.*

If we need to contact you by telephone from 9am to 4pm, New York time, which number(s) should we use?

Work Phone □ Home Phone □ Mobile Phone □

I expect to complete the training program in:

□ 1 year □ 2 years □ Don't Know Yet

Education & Work Experience

Highest Degree: ______________ Year Earned: __________ Field: ______________________________________

If you are applying from outside the US, please explain the degree(s) you have obtained, and the exact field of study. (Please explain how many years of study are involved, and whether your degree is closest to a Bachelor's, Master's, or Doctorate degree in the US.)

____

____

____

University (include city and country): ____

____

Describe your Internship, Practicum Work, or Residency (including name and location of Institutions):

____

____

____

Describe any Postdoctoral Training:

____

____

Licensure/Certification (if required in your country): _______________________________________

____

State/Country: ____

Essential: List previous workshops and training in Schema Therapy, if any (include approximate dates, locations, hours, and instructors; add additional page if necessary):

____

____

____

____

List the approximate hours per week you currently engage in the following professional activities:

_________ Direct patient contact

_________ Administration

_________ Research

________ Supervise Other Therapists

________ Take courses; study

________ Other activities (please specify):______________________

____

Main work setting/organization: ____

Current Position/Title: ____

I ***currently*** work with:

(Rate each category on a scale from 0-3 as follows: 0 =not at all, 1=occasionally, 2 =frequently, 3= almost always)

_____ Inpatients

_____ Outpatients

_____ Partial Hospital Patients

_____ Criminal offenders

_____ Children

_____ Adolescents

_____ Adults

_____ Geriatrics

_____ Individuals

_____ Couples

_____ Families

_____ Groups

_____ Other (please specify):_____________________________________

You may add additional pages if necessary to answer the following questions:

1. Please elaborate on your current professional work, including training, research, administrative and clinical activities.

2. Please elaborate on the nature and amount of clinical training ***in schema therapy*** you have already received.

3. Please describe your current psychotherapy orientation in detail, including the types of patients you work with.

4. Please elaborate on your general clinical training and previous clinical experience.

5. Describe your work with schema therapy, other than workshop training you have received (e.g. articles or books you have written, number of patients you have treated, supervisory or teaching experience, research you have participated in).

6. After completing the Institute training program, what kinds of professional activities do you expect to participate in related to schema therapy? (Please provide as much detail as possible.)

7. **To be a candidate for the training program, you must be sufficiently fluent in English to participate in the workshops, to understand master therapy sessions on DVD's conducted in English, and to read schema therapy materials in English.**

If you plan on obtaining certification, you also need to be sufficiently fluent to have individual case supervision sessions in English, and, if possible, to submit patient session recordings conducted in English. If this is not possible, we will try to find a certified rater who is fluent in your native language, but the tape rating costs could be higher.

Please answer the following:

A. I can submit audio or video recordings of actual patient sessions conducted in English:

1. YES __________ 2. NO__________ 3. UNCERTAIN ___________

If you answered NO or UNCERTAIN to question A above, please answer the following questions:

B. I can submit verbatim transcripts of actual patient sessions, translated into proper English:

1. YES __________ 2. NO__________ 3. UNCERTAIN ___________

C. I can submit audio or video recordings of actual patient sessions in the following language(s) other than English:

1. ________________________ 2. ________________________ 3. _______________________

8. Which level of certification are you applying for?

______ A. Advanced Certification
______ B. Standard Certification

I am *not* applying for certification now:

______ C. Intensive Workshop Training Only (October 2023 / January 2024 / April 2024)

9. If you are not applying for certification, please explain whether you plan to obtain additional training in schema therapy or certification in the future.

10. Is there any additional information about you that would be helpful to us in evaluating your application?

11. **Required**: On the following page, list two professional references who have supervised or observed your clinical work with patients. (The clinical work does not have to involve schema therapy, but ST is preferred.) Please ask them to forward a letter of reference directly to us at: wendy.behary@gmail.com

12**. Optional**: Attach the name(s) of one or more other references who can discuss non-clinical aspects of your accomplishments (including work with schema therapy if applicable), such as research, teaching, or administration. Please ask them to forward a letter of reference directly to our Institute at: wendy.behary@gmail.com

1st Clinical Reference:

Name: ____

Position: ____

Mailing Address: ____

____

Phone: ____

E-mail: ____

2nd Clinical Reference:

Name: ____

Position: ____

Mailing Address: ____

____

Phone: ____

E-mail: ____

Please Read and Check the Boxes Below:

☐ I understand that the standards set forth in this program may be slightly higher than those required by the Guidelines of The International Society of Schema Therapy (ISST). Required: Please put an X in the boxes below and add your name and date on the line indicated. If you will be using fax or postal mail, please sign on the line. If you will be applying by email, please *type* your name and date, or use an electronic signature.

☐ I understand that space is limited, and the workshop is only financially feasible for the Center(s) to offer based on the guarantee of a required minimal number of accepted candidates. Therefore, I understand, once my application is accepted and monies have been paid, there will be no reimbursements or refunds under any circumstances. I may have the option, space permitting, and at the sole discretion of the Directors, to apply unused monies I have paid to a future program or toward supervision—within the ***next 12-month*** calendar year.

☐ I understand if I am unable to attend the "full program" in 2023-24 I may be able to makeup "missed time" in 2024-25, providing there is a program offered and space available in the program. I am also aware that if space is not available, or the program is not being offered in a future calendar

year, there may be the risk that I will need to pay to attend another ISST-approved program to fulfill the obligations of the curriculum requirements (that I missed) to achieve certification.

☐ I understand that the ISST Guidelines hold forth that I must complete my certification no more than 3 years from the last day of the training program in the Spring of 2024.

By placing an X in the boxes above—and by typing or signing my name and the date on the lines below—I am accepting these terms as legally binding.

______________________________________ ____________________
Type or Sign Your Name Today's Date

Please send us your completed application by email (as a Word attachment), by fax, or postal mail. Our contact information is:

The Cognitive Therapy Center of New Jersey
Attn: Wendy T. Behary
28 Millburn Avenue, Suite 5
Springfield, New Jersey 07081
USA
Telephone: 001.973.218.1776 extension 807 or 808
Fax: 001.973.376.7726
E-mail: wendy.behary@gmail.com
or behary.assist@gmail.com