

WESTCHESTER CENTER FOR THE STUDY
OF PSYCHOANALYSIS AND PSYCHOTHERAPY

TREATMENT SERVICE

Completion of Supervision and Record Requirements

Psychoanalytic Training Program

SUBMIT to: ELAINE BIEBER, Ph.D., 34 Turner Drive, Chappaqua, NY 10514

Candidate Name: _____ Supervisor Name: _____

I have completed one of my required forty-hour blocks of supervision. During the course of that supervision, my training patient attended sessions at the required frequency of at least twice per week for at least 32 of the 40 session supervisory unit.

Signature of Candidate: _____

Signature of Supervisor: _____

Date: _____

My Treatment Service forms are up-to-date and all patient fees have been paid.

Checklist of Forms

1. Screening Report ___
2. Notification of Start of Treatment ___
3. Monthly Fee Payment Record – due at the end of each month ___
4. Treatment Progress Report – due 20th supervisory session ___
5. Treatment Progress Report – due 40th supervisory session ___
6. Termination Summary – if applicable ___

Signature of Candidate: _____

Signature of Supervisor: _____

Date: _____

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