

**Postgraduate Diploma/MSc in Sexual & Relationship
Psychotherapy
COURSE APPLICATION FORM**

NUMBER

Course (please select one of the following)

(Please tick)

MSc/PG Dip in Sexual and Relationship Psychotherapy	<input type="checkbox"/>
MSc/PG Dip/PG Cert in The Theory of Psychotherapy for Sexual Dysfunction	<input type="checkbox"/>
Sexual Medicine & Therapy	<input type="checkbox"/>
Psychotherapy Approaches	<input type="checkbox"/>
Sexual Function & Diversity	<input type="checkbox"/>

NAME:			
DATE OF BIRTH:		ETHNIC ORIGIN:	
HOME ADDRESS:			
HOME TEL NO:		MOBILE NO:	
EMAIL ADDRESS:			
WORK ADDRESS:			
WORK TEL NO:			
WORK EMAIL ADDRESS:			

**Postgraduate Diploma/MSc in Sexual & Relationship
Psychotherapy**

EDUCATIONAL QUALIFICATIONS		
Qualification	University/College/School	Date Obtained

PSYCHOTHERAPY OR COUNSELLING TRAINING		
Training Course or Programme	Training Authority / Academic Department	Dates of Training

Postgraduate Diploma/MSc in Sexual & Relationship Psychotherapy

Please describe any experience you have of working with sexual dysfunction or relationship difficulties.

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Psychotherapy**

Please describe your reasons for wishing to undertake specialist training in the assessment of sexual dysfunction.

Please add any other information in support of your application

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Please give the name and addresses of two referees who may be contacted about your ability for the course. Referees should be able to comment on your clinical skills and your academic and study skills.

Referee 1

NAME
ADDRESS
DAY TIME TEL NO
DAYTIME FAX NO
DAYTIME EMAIL ADDRESS

Referee 2

NAME
ADDRESS
DAY TIME TEL NO
DAYTIME FAX NO
DAYTIME EMAIL ADDRESS

Applicants Signature:.....

Date:.....

Please return to:

**Course Secretary
Porterbrook Clinic
Michael Carlisle Centre
75 Osborne Road
Nether Edge
Sheffield S11 9BF**