*SITE INFORMATIONFORM**

**This form must be completely filled in before our office will process and review your paperwork for Practicum or Internship approval. Any missing blanks will prevent students from being approved in the course.*

Name of Student: **Student Number**:

Please circle the course that you are applying for: Practicum Internship

Student's Full Address:

Student's tel. #: (home or cell): (work):

Agency/Site Name:

Agency/Site Address:

Name of Director: Position (title)

Agency/Site's tel. #: Fax #:

Usual Business Hours:

Please check <u>all</u> services that apply:

- ❑ Agency
- ❑ Private Practice
- ❑ Faith-Based Center
- ❑ University Counseling Center
- ❑ In-Home
- ❑ Inpatient
- ❑ Outpatient
- ❑ Day treatment
- ❑ Non-profit
- ❑ Other:

- ❑ Individual Adult
- ❑ Group
- ❑ Child
- ❑ Adolescent
- ❑ Marriage & Family
- ❑ Psycho-educational groups
- ❑ Substance Abuse
- ❑ Rehabilitation
- ❑ Other:_____

Please list <u>three</u> or more examples of the weekly fieldwork duties that the student will be performing:
-At least one work duty needs to count towards <u>Direct Client Contact</u>.

1)_____

2)_____

3)_____

Is the student employed with this site?_____

If yes, please list the **1) Name** and **2) Job Title** of the **<u>employment supervisor</u>**:
-The employment supervisor <u>cannot</u> be the same as the Practicum/ Internship Supervisor

<u>1</u>)_____ **2**)_____

Site Director, please initial the following statements:

- I confirm that this site is an established counseling center - **Initial Here**:_____
- I confirm that this site has a licensed mental health professional on-site - **Initial Here**:_____

_____ _____

Director's Signature **Date** **Student's Signature** **Date**

*SUPERVISORINFORMATIONFORM**

**This form must be completely filled in before our office will process and review your paperwork for Practicum or Internship approval. Any missing blanks will prevent students from being approved in the course.*

Name of Student:_____ **Student Number**:_____

Student's Full Address:_____

Student's tel. #: (home or cell):_____(work):_____

Student's Liberty email address: _____

Agency/Site Name: _____

Agency/Site Address: _____

Group Supervision is provided at this site: ❑ Yes ❑ No

WebEx Faculty Group Supervision is a requirement. Additionally, students are encouraged to find sites that provide Group Supervision.

This site will allow taped (either video or audio) sessions with clients: ❑ Yes ❑ No

Please **check the box** confirming there is **no** dual relationship* that would impair your judgment or limit your ability to remain objective with your supervisee (e.g. family/personal relationship, direct work supervisor, etc.). ❑ **No Dual Relationship**

**Dual Relationship* is a situation where multiple roles exist that could influence the overall ability to provide objective feedback and guidance to the supervisee, thus causing harm to the supervisee.

Name of Supervisor: ❑ Mr. ❑ Ms./Mrs. ❑ Dr. _____

Position (title) _____

Supervisor's tel. #: (work):_____Supervisor's Email: _____

(Required) ***(Required)***

Academic Background of Supervisor:

Degree	Major	Year Received	Educational Institution

Licenses and Certifications Currently Held by Supervisor:

Type	Number	State Where Valid	Expiration Date

Clinical and Supervisory Experience

I certify that I am fully licensed as an independent practitioner in counseling and have at least 2 years of clinical experience in the area I am supervising: **Yes** □ **No** □

Have you completed any supervision training (workshops, graduate level course, CE's etc.): **Yes** □ **No** □

_____ _____

Supervisor's Signature **Date** **Student's Signature** **Date**