

## **SITE INFORMATION FORM\***

*\*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 all services that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Agency                       | <input type="checkbox"/> Individual Adult          |
| <input type="checkbox"/> Private Practice             | <input type="checkbox"/> Group                     |
| <input type="checkbox"/> Faith-Based Center           | <input type="checkbox"/> Child                     |
| <input type="checkbox"/> University Counseling Center | <input type="checkbox"/> Adolescent                |
| <input type="checkbox"/> In-Home                      | <input type="checkbox"/> Marriage & Family         |
| <input type="checkbox"/> Inpatient                    | <input type="checkbox"/> Psycho-educational groups |
| <input type="checkbox"/> Outpatient                   | <input type="checkbox"/> Substance Abuse           |
| <input type="checkbox"/> Day treatment                | <input type="checkbox"/> Rehabilitation            |
| <input type="checkbox"/> Non-profit                   | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Other:                       |  |

Please list three or more examples of the weekly fieldwork duties that the student will be performing:

-At least one work duty needs to count towards Direct Client Contact.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Is the student employed with this site? \_\_\_\_\_

If yes, please list the **1) Name** and **2) Job Title** of the **employment supervisor:**

-The employment supervisor cannot be the same as the Practicum/ Internship Supervisor

1) \_\_\_\_\_

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**

# **SUPERVISOR INFORMATION FORM\***

*\*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: \_\_\_\_\_

**1. Group Supervision is provided at this site:**      Yes      No

\*Group Supervision is a requirement for CEFS 699 Internship. The group supervision requirement is met by earning Group Supervision hours on-site (Minimum of 25 Hours). If site is not able to provide the student with group supervision, the student must add a 2nd site and a 2nd supervisor to meet the requirement for Group Supervision.

**2. This site will allow taped video sessions with clients:**      Yes      No

**3. 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**

Have you completed any online supervision training: **Yes**  **No**

\_\_\_\_\_  
**Supervisor's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Student's Signature**

\_\_\_\_\_  
**Date**