Name of Applicant:												
Summary of Pre-Internship Supervised Professional Experiences												
Abbreviated Title of Training Site	**Dates of Supervised Experience (From & To; MM/YY) Listed Chronologically**	**Semester(s)**	**Class Number**	**Total Number of Supervised Hours**	**Direct Client/Patient Contact Hours**	**Hours worked per week**	**Total Face to Face Individual Supervision**	**Total Face to Face Group Supervision**	**Total Face to Face (Group + Individual) Supervision**	**Weekly Face to Face Individual Supervision**	**Weekly Face to Face Group Supervision**	**Weekly Face to Face (Individual+ Group) Supervision Totals**
Example Best Mental Hlth Clinic	*Sept 08 May 09*	*Fall 2008; Spring 2009*	*CPY 639; CPY 639*	*297*	*100*	*9*	*30*	*0*	*30*	*1*	*0*	*1*
GRAND TOTAL (EACH COLUMN)												

INSTRUCTIONS:
If not applying preinternship hours towards licensure, applicant may leave this page blank.

Follow format in example (e.g., Best Mental Hlth Clinic) for each entry

Each experience/site listed in this summary must be verified by the educational institution on the Supervised Preinternship Verification Form. Duplicate page 2 of verification form as needed.

Enter N/A for class number if experience is not associated with a specific class

Please refer to A.R.S. §32-2071 (E) for information pertaining to preinternship requirements