TO BE COMPLETED BY THE APPLICANT AND VERIFIED BY THE EDUCATIONAL INSTITUTION:
List in chronological order each place of supervised preinternship experience for which you are claiming hours.
Please print. Use additional copies of this page as needed.

Name of Facility/Training Site:				Phone:	
Address:			City & State:		
Dates of Supervised Experience		From:		To:	
Applicant's working title:					
Term/Class number/title in which you received academic credit for this experience (e.g., Fall 2009, PSY 660 Practicum)*:					

**Note: If academic experience was not received for this experience, please attach an explanation.*

_____ Total Number of Supervised Experience Hours

_____ Total Hours of Direct Patient/Client Contact

_____ Number of Hours Worked per Week

_____ Total hours of face-to-face supervision distributed as follows:

_____ Total Hours of Individual Supervision

_____ Total hours of Group Supervision

_____ Hours of Face to Face Supervision per Week distributed as follows:

_____ Hours of individual supervision per week

_____ Hours of group supervision per week

Description of Training: _____

_____

_____

Name of Faculty Supervisor: _____

Name of Primary Supervisor: _____ Title: _____

Profession of Primary Supervisor: _____ License No. _____ State: _____

Name of Secondary/Other Supervisor: _____ Title: _____

Profession of Secondary/Other Supervisor: _____ License No. _____ State: _____

Verified by (To Be Completed by Doctoral Program Training Director, Faculty Supervisor, or Other Institution Official):

Signature: _____ Address: _____

Printed Name: _____ City & State _____

Title/Position: _____

Institution: _____ City & State: _____

Email Address: _____