APPENDIX VIII

CLINICAL INTERNSHIP AGENCY OPENING FORM

Official Name of Agency: _____
Department (if applicable):_____
Address: _____
City, State, Zip: _____
Phone #:_____

Name and Title of Agency Internship Coordinator or Contact Person:
_____
_____
E-Mail address of Above Person: _____

Please describe your agency's area of specialization or area(s) in which interns would be most involved, e.g. aging; outpatient mental health; child welfare:
_____
_____
_____
Hours and Days of Agency Operation:
_____
_____
Agency's Primary Function and Program Objectives:
_____
_____
Brief Description of Intern Learning Assignments:
_____
_____
_____
Are there persons licensed to provide mental health counseling available to supervise intern (e.g. psychiatrist, psychologist, social worker, mental health counselor)? _____

Is the student allowed to audio/video tape sessions with client's written permission? _____

Name & Title of Person Who Completed this Form:_____
Date Form Completed: _____

*Clinical Internship need not have any pastoral component and may be entirely secular in orientation.