

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: _____

Group Supervision is provided at this site: ☐ Yes ☐ No*

***Group supervision is a requirement of the COUN 699 Internship course.** 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.

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 Experience & Other Relevant Information

I certify that I have at least 2 years of clinical experience in the area I am supervising: Yes ☐ No ☐

Supervisor's Signature

Date

Student's Signature

Date

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:

- ☐ 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 at least three examples of the weekly fieldwork duties that the student will be performing:

Will the student be paid at this site? _____ If so, what are the conditions? _____

Director's Signature

Date

Student's Signature

Date