Internship Approval Form Marriage and Family Therapy Master and Certificate Program

Student Information

Name ____________________________________________________________

Address _______________________________________________________

Phone: _________________________________________________________

Semester: _______ Fall _______ Spring _______ Summer _______

Internship Site Information

Site Name: ______________________________________________________

Address: ______________________________________________________

Phone: _________________________________________________________

Supervisor: ____________________________________________________

Title: _________________________________________________________

Degree ___________________________ Licensure ___________________
Brief Description of Internship

Individual Therapy Experience:

Couple/Family Therapy Experience:

Group Therapy Experience:

Other Professional Experiences Available to Students:

Description of Supervision

One hour of individual face-to-face supervision provided per 20 hour of Internship by: ________________________________

Licensed Number: ________________________________

Approval (Not valid without all signatures)

In signing this form I understand that Saint Cloud State University, the Internship site supervisor(s) and the Internship supervision class (CPSY 696) professor may consult on my progress in my internship for training purposes.

Student ________________________________ Date ________________

Site Supervisor ________________________________ Date ________________

Saint Cloud State University Supervisor

St. Cloud State University: 720 Fourth Avenue South; St. Cloud, MN 56301 320-308-2160 FAX: 320-308-3216