

APPENDIX V: Student Sign-Off Sheet

CMHC Graduate Student Handbook and Clinical Experience Handbook

Clinical Mental Health Counseling Program
Saint Cloud State University
Department of Community Psychology, Counseling and Family Therapy

I, _____, have read both the Graduate Student Handbook **and**

(PRINT NAME)

Clinical Experience Handbooks for the Clinical Mental Health Counseling Program. I agree to abide by the policies, procedures and ethical standards of the Clinical Mental Health Counseling program, and agree to participate in the Clinical Mental Health Counseling Program's ongoing evaluation process as described in the Program Evaluation Section of the Graduate Student Handbook.

I have read the Graduate Student Handbook: _____
Student Signature Date

I have read the Clinical Experience Handbook: _____
Student Signature Date

I further agree to allow data obtained for program evaluation to be used in future program authorized research. All information obtained by program evaluation will be held in confidence according to the St. Cloud State University policy. All data released for research purposes will be done so in an anonymous format.

Student Signature Date

I further agree to participate in annual surveys provided by the program faculty in accordance with CACREP compliance. I allow data obtained for program evaluation to be used in future program authorized research. All information obtained by program evaluation will be held in confidence according to the St. Cloud State University policy. All data released for research purposes will be done so in an anonymous format.

Student Signature Date

I agree to notify the department within 10 days of any change of address, e-mail, or name in order for the department to remain able to contact me for the annual program review survey. This aligns with the BBHS requirement of 10 day notification of similar updates.

Student Signature Date