

## **PRACTICUM SITE APPROVAL FORM**

*To be filled out and submitted prior to the start of the first class session*

### **Student Information:**

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Last Name	First Name	Middle Initial
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Address

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City	State	ZIP
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Phone Number (Daytime)	(Evening)
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Email Address (PRINT)

### **Practicum Information:**

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Agency

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Address

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City	State	ZIP
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Phone Number	Fax Number
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Practicum Supervisor

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Practicum Supervisor Email Address

**Practicum Supervisor's Degree:**

BS  MS  MSW  PhD  PsyD  MD  Other

**Practicum Supervisor's Credential:**

CCS  CADC-I  CADC-II  LMSW  LPC  LMFT

Is the practicum site at a non-profit agency?  YES  
 NO

**Type of Agency:** *(Check all that apply)*

- |  |   |
|--|---|
| <input type="checkbox"/> Outpatient Mental Health Clinic   | <input type="checkbox"/> In- Home Mental Health       |
| <input type="checkbox"/> Residential Treatment Center      | <input type="checkbox"/> Rehabilitation Hospital      |
| <input type="checkbox"/> Outpatient Substance Abuse Clinic | <input type="checkbox"/> Outpatient Private Practice  |
| <input type="checkbox"/> General Medical Hospital          | <input type="checkbox"/> Community Outreach Program   |
| <input type="checkbox"/> Inpatient Psychiatric Hospital    | <input type="checkbox"/> University Counseling Center |
| <input type="checkbox"/> Corrections Facility              |   |

**Client Population Student Will See:**

- |                                     |                                      |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Children   | <input type="checkbox"/> Adult       |
| <input type="checkbox"/> Adolescent | <input type="checkbox"/> Older Adult |

**Training Experiences Provided:**

- |   |  |
|---|--|
| <input type="checkbox"/> Individual psychotherapy   | <input type="checkbox"/> Crisis intervention     |
| <input type="checkbox"/> Group psychotherapy        | <input type="checkbox"/> Health services         |
| <input type="checkbox"/> Family/Couples programming | <input type="checkbox"/> Educational programming |

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Student Signature

Date

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Supervisor Signature

Date

**Once complete, please fax form to (603) 843-5914 or mail to  
DLCAS, P.O. Box 240663, Apple Valley, MN 55124.**