POST INTERNSHIP SURVEY

1. Name of Intern_____________________________________ Psy.D.____ Ph.D.____

2. Internship Name________________________________________________________

3. Internship's Address_____________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

4. Patient populations worked with (e.g., chronically mentally ill, rehabilitation patients, eating disordered) and percentage of internship time devoted to each:

<table>
<thead>
<tr>
<th>Population</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</table>

5. Name and Title of Supervisor(s):

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
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<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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</tbody>
</table>

6. Dates of Internship:
Beginning Date _______________ Ending Date _______________

Total Number of Hours Worked _____________

7. Internship Activities (average hours/week):

a) Patient Contact:
   1. Testing: ___________ hrs/week
   2. Therapy: ___________ hrs/week
   3. Consultation/Education: ___________ hrs/week
   4. Other (please specify): ___________________________ hrs/week

b) Supervision: ___________ hrs/week

c) Case conferences/staffings ___________ hrs/week

d) Research ___________ hrs/week

e) Supervision of others: ___________ hrs/week

f) Other (please specify) ___________________________ hrs/week

8. Evaluations

a) Overall rating of internship a learning experience (circle one):
   1-poor    2-fair    3-good    4-very good    5-excellent

b) Rating of overall quality of supervision (circle one):
   1-poor    2-fair    3-good    4-very good    5-excellent

9. Comment on the positive aspects of this internship:
10. Comment on the negative aspects of this internship:

11. Did you feel adequately prepared for this placement?  Yes______  No______
    If NO, what specific prior training would have been useful?

12. Would you recommend this internship to future Nova Southeastern University interns?  Yes_____  No______

13. If YES, what suggestions do you have regarding the application process and/or functioning as an intern?

14. Have you completed all other requirements for your degree (e.g., dissertation or directed study)?  Yes_____  No_____   
    If  NO, what program requirements remain:

15. My plans are to: (check all that apply)
16. My address upon completion of internship will be:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Phone number:______________________________________________________

17. Where are you planning to be employed after internship? (Please specify if Post-doc)

Employer name:______________________________________________________

Address:____________________________________________________________

Position/Title:________________________________________________________

Full-time_______ Part-time_______

18. Please specify what percentage of your time will be devoted to each of the following activities:

Academic/Teaching:___________________________________________________
Academic/Research:__________________________________________________
Clinical:____________________________________________________________
Administrative:_______________________________________________________
Other (please specify):_________________________________________________

19. Using the following scale, please rate both your doctoral training at Nova and your internship training regarding your preparation for each of the following activities:
<table>
<thead>
<tr>
<th></th>
<th>NOVA</th>
<th>INTERNSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>poor</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>fair</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>adequate</td>
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<td></td>
</tr>
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</table>

teaching ______________  ______________
research ______________  ______________
clinical ______________  ______________
administrative ______________
supervision ______________
consultation ______________
other (specify) ______________

Student's Signature ____________________________________________

Date ________________________________

Return to:  Alan D. Katell, Ph.D.
Director of Clinical Training
Nova Southeastern University
3301 College Avenue
Ft. Lauderdale, FL  33314