Insert Program Name Here

Practicum Site Information

Date Last Modified	
Program/Institution	
Department	
Street # and address	
City, State, Zip	
Web Address/Contact Email	

TOTAL NUMBER OF PLACEMENTS AVAILABLE IN THE COMING YEAR

THE INFORMATION IN THIS SECTION MUST BE FILLED IN EVERY YEAR

Total # Total Doctoral Students WE WILL TAKE FROM NOVA this coming year: ___	
Of total # of students, # that are Summerstarts(May through April)___	**Of total # of students, # that are FALL**starts(end of Aug through mid Aug)___
Further description of # of SUMMER student starts _____ 1st year practicum _____ 2nd year practicum _____ Elective (12 months)	**Further description of # of FALL student starts** _____ 1st year practicum _____ 2nd year practicum _____ Elective (12 months)

SPECIAL PROGRAM REQUIREMENTS

THE INFORMATION IN THIS SECTION MUST BE FILLED IN EVERY YEAR

√ Please check all requirements that apply to your site for practicum students

____ Level 1 Screen Required	____Level 2 Screen Required
____Fingerprints Required	____Do **YOU** conduct the background checks
____Drug Test Required?	____Do **YOU** conduct the drug tests
____Physical Required	____TB Screening Required
____Proof of Health Insurance Required	____Physician's Statement of Readiness for Practicum Required
____Proof of Immunization Required	____Interview Required
____Spanish Speakers Only	____1 Spanish Speaker Preferred
____1 Male Preferred	____Other:_____

____Are there mandatory training sessions before starting?If yes describe:
Other Required Training Prerequisites (classes, degrees, experience, etc):
Can students tape sessions with clients with an informed consent? ____Yes ___ No

Describe Specific Site Requirements

Minimum number of hours/week	1st Year practicum: ___ 2nd Year practicum: ___ Elective practicum: ___
Attendance at specific meetings	
Other requirements	
List specific evening hours required	
# Direct clinical contact hours/week	1st Year practicum: ___ 2nd Year practicum: ___ Elective practicum: ___
Supervision Requirements (e.g., individual, group, time, day)	

Contact Person/Supervisor Information

Contact Person/Supervisors	Name: Email: Phone:

Short Program Description

Clinical Description of Program

√ Please check all requirements that apply to your site for practicum students

Client Populations

	Adolescents		Infants		Children
	Adults		Older Adults		College Students
	Other _____				

Assessment

	Personality		Intelligence		Neuropsychology
	Behavioral/Cognitive		Forensic		Physiological

Treatment Modality

	Individual		Group		Brief (4 -12 sessions)
	Family		Couples		Short-term (3-6 months)
	Crisis Intervention		Other: _____		Long-term (6+ months)

Theoretical Orientation

	Eclectic		Behavioral Medicine		Humanistic
	Cognitive		Dynamic		Systems
	Gestalt		Behavioral		Other:_____