

SCHOOL COUNSELING INTERNSHIP

Student Information Approval Form

This form must be filed with the Xavier University Clinical coordinator to request approval to begin the internship.

Name: _____

Address: _____

Phone: Work _____

Home _____

Semester: _____

Supervisor Name: _____ Title: _____

School name: _____

Address: _____

Phone: _____

Supervisor Degrees/certification/licenses held: _____

Brief Description of Expected Experiences: _____

Anticipated Number of Clock Hours to Be Completed at this site: _____ hrs.

Student Signature

Date

Approved: _____, Clinical Coordinator, _____
(Signature) *(Date)*

PART B: TO BE COMPLETED BY THE TRAINING SUPERVISOR

Instructions to supervisor:

After completing this form, please return it to the supervisee who is responsible for returning it to Xavier University.

1. Are you a licensed or certified as a School Counselor?

[] Yes [] No Grade Levels? _____ State? _____

2. If you are not a licensed school counselor, what license do you hold? _____

3. Please briefly describe the nature of the supervision to be provided: _____

4. Briefly describe your experience in training supervision _____

5. I HAVE REVIEWED THE SUPERVISEE'S STATEMENTS.

THEY (ARE _____) (ARE NOT _____) ACCURATE

Supervisor's Signature

Date

