

# DOCUMENTATION OF TRAINING SUPERVISION

*Please complete a separate form for each of your clinical training supervisors.*

## Part A. To be completed by trainee

Trainee Name: \_\_\_\_\_

Supervised Clinical Training was provided while enrolled as a graduate student in:

Department: \_\_\_\_\_

College/University: \_\_\_\_\_

Academic credit was provided for supervised clinical training shown below. Please provide information as it appears on your academic transcript:

Academic Year: \_\_\_\_\_

Semester(s) / Quarter(s): \_\_\_\_\_

Course Number and Title: \_\_\_\_\_

Grade(s): \_\_\_\_\_

## Part B. To be completed by clinical supervisor

Supervisor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Highest Degree: \_\_\_\_\_

Were you a licensed clinical psychologist at the time of supervision? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide license number and state in which licensed: \_\_\_\_\_

If no, were you licensed/certified in another profession? \_\_\_\_\_

If yes, provide license /certification number and state: \_\_\_\_\_

Clock hours per week supervisee was engaged in clinical training under your supervision: \_\_\_\_\_

Total hours of practicum experience at this placement: \_\_\_\_\_

Type of Clinical Activity (Direct Service) – include number of service hours provided:

Intake: \_\_\_\_

Psychological Assessment (include face-to-face time only, not report writing): \_\_\_\_

