

SITE INFORMATION SHEET

Student: _____

Phone: _____ E-mail: _____

Internship Site: _____

Agency/Site Director: _____

Site Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Primary On-Site Supervisor: _____

Phone: _____ E-mail: _____

Degree & Discipline: _____ License/Cert.: _____

Years of post-Master clinical experience: _____

Years of experience supervising students: _____

Secondary On-Site Supervisor: _____

Phone: _____ E-mail: _____

Degree & Discipline: _____ License/Cert.: _____

Years of post-Master's clinical experience: _____

Years of experience supervising students: _____

Group Supervision? no yes

If yes, please provide the following information:

Name & credentials of group supervisor: _____

Frequency of group supervision: _____

Duration of group supervision: _____

Number of participants: _____