St. Cloud State University
Community Psychology, Counseling, and Family Therapy Department
Educational Leadership

Internship Approval Form Marriage and Family Therapy Master and Certificate Program

Student Information

Name ____

Address ____

Phone:

Semester: _________Fall ________ Spring ______Summer_______

Internship Site Information

Site Name:____

Address:____

Phone:____

Supervisor:____

Title:____

Degree __________________________Licensure___________________

Brief Description of Internship

Individual Therapy Experience:

Couple/Family Therapy Experience:

Group Therapy Experience:

Other Professional Experiences Available to Students:

Description of Supervision

One hour of individual face-to-face supervision provided per 20 hour of

Internship by:____

Licensed Number: ____

Approval (Not valid
without all signatures)

In signing this form I understand that Saint Cloud State University, the Internship site supervisor(s) and the Internship supervision class (CPSY 696) professor may consult on my progress in my internship for training purposes.

Student ___________________________________ Date _________________

Site Supervisor ____________________________ Date _________________

Date

Saint Cloud State University Supervisor

St. Cloud State University: 720 Fourth Avenue South; St. Cloud, MN 56301 320-308-2160 FAX: 320-308-3216