

Department of Family Therapy

INTERNSHIP STUDENT INFORMATION SHEET

(Please return this form to the office of the Internship Coordinator before beginning Internship)

Date _____

M.S.

Ph.D.

DMFT

Last Name _____ First Name _____

Address _____ City/State/Zip _____

Telephone (HOME) _____ (WORK) _____ (CELL) _____

Best time to Call _____ NSU E-mail: _____

TERM AND YEAR YOU STARTED PROGRAM: _____

1. What sites interest you or what populations are you interested in working with?

2. What date will you be available to begin your internship _____

3. Days and times you are available _____,

_____, _____,

4. Do you have a preference for your site location? (City, County, etc.) _____

IF YOU ALREADY HAVE SITE

1. Name and location of site _____

2. Contact person and telephone _____

3. Site supervisor (include credentials, i.e., licensed, experience, AAMFT) _____

4. Opportunity for Relational Hours

Yes

No

5. Anticipated start date _____

6. Days and times will you be interning at site _____

Please provide a completed copy of the Internship Site Contract for each internship site you have established.