Application for MA Counseling Practicum/Internship

Effective Date 10/1/18

Purpose

Each student in the Master of Arts of Counseling program must complete an application for Practicum/Internship and submit the signed form by email to the Director of Clinical Training (DTC). This form must be approved by the DCT prior to a student participating in any Practicum/Internship hours. **Email:** rcc@rockies.edu.

Student Information

First Name: _____ Last Name: _____ Student ID: _____

City: _____ Sate: _____ Zip Code: _____

Day Phone: _____ Email Address: _____

Previous Education

Previous graduate degree(s): ☐ Yes ☐ No Area(s) of study: _____

Do you hold a mental health clinical license? ☐ Yes ☐ No If yes, what kind? _____

Did you transfer in any clock hours of clinical or counseling Practicum/Internship? ☐ Yes ☐ No

If yes, how many hours? _____

Practicum/Internship at Ashford University

What Practicum/Internship are you applying for? Please check one:

☐ Addiction Counseling ☐ Clinical Mental Health Counseling ☐ Marriage, Couples, and Family Counseling

Anticipated first term of Practicum/Internship: _____

Do you work during the day? ☐ Yes ☐ No

Area of interest or academic concentration: _____

How do you intend to complete the required weekly hours in the Practicum/Internship? Please explain:

Acknowledgement

By signing below, I acknowledge all information provided on this form is true and correct to the best of my knowledge.

Student Signature: _____ Date: _____

For Office Use Only

Verification of the following:

- Liability Insurance Dates: _____
- Proof of professional licensure (if applicable): _____

Director of Clinical Training (DCT) confirmed _____ number of clock hours being transferred in for Practicum/Internship with the Registrar's Office (if applicable).

DCT Decision: ☐ Approved ☐ Denied

Director of Clinical Training Signature: _____ Date: _____