**University of Oregon Clinical Psychology Program**

**Request for Approval for Off Campus Clinical Work**

**Name**: **Year in Program**:

**Academic Advisor**:

**Completed in-house practica**:

**Site of proposed clinical work**:

**Period of Proposed work**:

**Site supervisor and credentials**:

**Site Address**:

**Phone**:

**Email**:

1. **Description of clinical activities**:

 (Please include clients, assessments, treatment format and modality, manuals to be used, report writing, etc)

2. **Approximate number of face to face client hours per week**:

3. **Supervision agreement**:

 (Please include name of supervisor, credentials of supervisor, supervision format, frequency of supervision)

4. **Other activities at site** (e.g. team meetings, etc):

5. **Please describe how your clinical work at this site would be consistent with our clinical scientist training model**:

6. **Please describe how clinical work at this site would support and further your individual training needs and goals**:

Student signature:

Date:

**University of Oregon**

**Department of Psychology**

**Approval of Student Request for Off Campus Clinical Work**

A student in our doctoral program in clinical psychology is requesting approval for clinical work under your supervision at your site. Please review the student’s request and indicate your agreement.

I have read and agreed with this proposal for clinical work. It is understood that the student has not completed the PhD program and is not licensed as a psychologist. Therefore, neither the student nor the practicum site will represent the student as a psychologist. The site or the student will inform clients that the graduate student is providing services as part of professional training.

The site is in compliance *with APA Ethical Principles of Psychologists* and *APA Standards for Providers of Psychological Services*.

Supervisor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed psychologist’s name, if supervisor is not a licensed psychologist: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed psychologist’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approval from current Director of Clinical Training:

DCT’s name: Philip A. Fisher, PhD

DCT’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_