 **Department of Counseling & Student Affairs
Clinical Mental Health / Marriage, Couple, & Family
Internship Site & Supervision Contract**

**Student Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | WKU ID (800#) |  |
| Topper Email |  | Phone |  |
| Program |  | Faculty Advisor |  |

**Clinical Term & Site Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Internship Term | Fall / Spring | Year |  |
| Contract Dates: From |  | To |  |
| Site Name |  |
| Site Supervisor |  |
| Faculty Supervisor |  |

**Internship Site & Supervision Contract Checklist**In order for this contract to be considered complete, submit all of the following documents electronically; check that you have completed them.

|  |  |  |
| --- | --- | --- |
|[ ]  Complete and submit *Internship Site & Supervision Form* (this form) | Date |  |
|[ ]  Download & attach a copy of the *Site Information Form* (from the [Approved Practicum & Internship Sites](http://www.wku.edu/csa/counseling/approved_sites.php)); review the form for accuracy and have the site supervisor update it if necessary. This will provide the details of your site and site supervisor information to accompany this contract.  | Date |  |
|[ ]  Attest that you have reviewed the [Practicum and Internship Manual](http://www.wku.edu/csa/counseling/documents/practicum_internship/prac-intern-manual.pdf) and are familiar with the roles and responsibilities of the practicum student, faculty group supervisor, site supervisor, and clinical coordinator. | Date |  |
|[ ]  Confirm that you have read and will comply with the Department policy on [Security of Media](https://www.wku.edu/csa/policies/practicum_policies.php) (Video and Audio) to meet HIPAA standards. | Date |  |
|[ ]  Indicate your preferred internship course section if more than one section is available. | Section |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Student’s Signature |  | Date |
|  |  |  |
| Site Supervisor’s Signature |  | Date |
|  |  |  |
| Faculty Supervisor’s Signature  |  | Date |

|  |  |  |
| --- | --- | --- |
| Clinical Coordinator’s Signature  |  | Date |