



**Section II: Certification of Supervised Internship and Practicum**

**Instructions to Chair or Director:** Please complete Section II before sending all pages of this form along with any other required documentation in an official envelope directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant or any other party. Note: Syllabi cannot be accepted in lieu of completion of this form.**

Name of applicant: \_\_\_\_\_  
*(Section I, item 3)*

Name on Institution records: \_\_\_\_\_

Course number(s): \_\_\_\_\_ Semester(s) Taken: \_\_\_\_\_

Institution: \_\_\_\_\_

Name and Location of internship/practicum (include city/state): \_\_\_\_\_

Total number of clock hours: \_\_\_\_\_ Number of direct client contact hours: \_\_\_\_\_

Was the field site approved by the Institution?       **Yes**       **No**

What were the qualifications of the on-site supervisor (ex. licensure in a profession or national certification in counseling)?

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

How many hours of on-site, face-to-face supervision were there? \_\_\_\_\_

How often was the on-site supervisor required to submit evaluations to the institution?

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

How did the institution supervise the internship/practicum?

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

Please describe the mental health counseling services provided by the student in the practicum/internship (Attach additional sheets if necessary)

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

Please identify the **clinical mental health and psychotherapy diagnostic and assessment tools** that were used by the student. Some examples are DSM, SCID, ICD-10. (Attach additional sheets if necessary)

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Please explain how the student prepared a therapy plan and provided mental health counseling under supervision. (Attach additional sheets if necessary)

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**Certification**

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Counseling Unit, 89 Washington Avenue, Albany, NY 12234-1000.**