

942 Learning Way, Suite 250 Tallahassee, Fl 32306 Phone: 850-645-8255 (TALK)

Fax: 850-644-3150

## **Doctoral Practicum Training Program Application Form**

\*\*\*Please Type or Print the following information: \*\*\*

Last Name	First		Middle		
Preferred Name					
Local Address	City			State	Zip
Home/Cell Phone	E-mail				
Current Doctoral Program	Class ranking [1st	year, 2nd year, etc.]:			
Highest Degree Earned/Ye	ar Earned:				
Name of Academic Institut	ion in which Highe	est Degree Earned:			
Anticipated Graduation Da	te:				
Please, list up to four	practicum sites	and include the	requested infor	mation for each	site below:
Practicum site name AND client population [ie. children (ages 3 to 9), adolescents (ages 10 to 17), young adults (ages 18 to 24), adults (ages 25 and up)]	Number of hours worked per week	Start and End date	Average number of clients seen per week	Average number of sessions per client	Type of counseling services provided

Please note that applicants who are offered and accept a practicum placement are required to attend a week long orientation the week before the start of the Fall semester. Your signature below will indicate that you understand and agree to comply with this requirement.

Signature Date Revised June 29, 2021