

POST INTERNSHIP REPORT

(Completed by the student at the end of the experience)

Internship Site: _____

Address: _____

Phone: _____

Supervisor: _____

Typical Clientele at Site:

Your program track:

Mental Health _____ School _____

Was it difficult to get all of your internship hours at this site?

_____ No, I did not have problems getting hours at this site.

_____ Yes, it was difficult because:

Is there a minimum commitment to do a practicum/internship at this facility?

Yes, _____ hours per week

Yes, _____ semesters

Other _____

No, _____ there is no minimum commitment.

What was the best aspect of this site? (Clients, facility, supervision, etc.)

What could be improved about this site? (Clients, facility, supervision, etc.)

What the prevailing philosophy or theoretical orientation approach at this site?

Has this site had ECU interns before? Yes ____ No _____

From what other schools/ programs does this site take interns?

On a scale from 1-10, (10 being the best) how would you rate:

The facility _____

Supervision _____

Training _____

Overall _____

Any other information that you feel would be helpful to someone considering this site for an internship:

Did this site meet your expectations? Explain.

Are there job possibilities at this site for interns? YES ____ NO _____

Your
name: _____

Address:

Phone number:

Email address:

Term/ Year completed internship:

May a student from the EKU program contact you for more information about this internship site?

No, _____ I prefer not to be contacted.

Yes, _____ I would be happy to assist another student. Please contact me

via:

◇ phone _____

◇ email _____

◇ home address _____

Eastern Kentucky University Counseling and Educational Psychology

PERMISSION TO RECORD/OBSERVE

I, _____, hereby give my
(Name of Client/Guardian)

permission for the use of video- recording devices, as well as observation through
a one-way mirror _____ during my counseling session with

_____ at/from Eastern Kentucky
University (Name of Student Counselor)

in conjunction with

(Site Name and Address)

I understand that any information obtained during counseling sessions through
these means will be used solely for the purpose of supervision by my counselor's
supervisor(s), and that otherwise this information will be kept strictly confidential.

This authorization will expire on _____ or when I
(Date)

terminate my counseling with the above named counselor. I also understand that
any taped material will be summarily erased after supervision has taken place.

Date Client Signature