

**CLINICAL MENTAL HEALTH COUNSELING
PRACTICUM/INTERNSHIP SITE PRE-SELECTION DATA FORM**

Student: _____ Date: _____

Name of Agency/School: _____

Address _____ State _____ County _____ Zip code _____

Telephone: _____

Site Supervisor Name: _____

Direct Phone Line: _____

Email: _____

Degree Held: _____

Years of Counseling Experience: _____

Professional Licensure/Certification Held (NCC, LPC, LMFT, LCAS, MAC, CCSW, or specify): _____

Professional Memberships (ACA, NCCA, AAMFT, NCAAMFT, or specify):

Type of Direct Service Provided

Individual counseling	Yes _____	No _____
Couples counseling	Yes _____	No _____
Family counseling	Yes _____	No _____
Child/Adolescent counseling	Yes _____	No _____
Group counseling	Yes _____	No _____
Career counseling	Yes _____	No _____
Intake Assessments	Yes _____	No _____
Consultation services	Yes _____	No _____
Referral services	Yes _____	No _____
Testing interpretation	Yes _____	No _____