University of Oregon Clinical Psychology Program
Request for Approval for External Clinical Work

Name: 

Year in Program: 

Academic Advisor: 

Completed in-house practica: 

Site of proposed clinical work: 

Period of Proposed work: 

Site supervisor and credentials: 

Site Address: 

Phone: 

Email: 

1. Description of clinical activities and population served (e.g., child, adolescent): (Please include clients, assessments, treatment format and modality, manuals to be used, report writing, etc)

2. Approximate number of face to face client hours per week: 

3. Supervision agreement: (Please include name of supervisor, credentials of supervisor, supervision format, frequency of supervision) 

4. Other activities at site (e.g. team meetings, etc): 

5. Please describe how your clinical work at this site would be consistent with our clinical scientist training model: 

6. Please describe how clinical work at this site would support and further your individual training needs and goals: 

Student signature: 

Date: 

Revised 10/17/19
A student in our doctoral program in clinical psychology is requesting approval for clinical work under your supervision at your site. Please review the student’s request and indicate your agreement.

I have read and agreed with this proposal for clinical work. It is understood that the student has not completed the PhD program and is not licensed as a psychologist. Therefore, neither the student nor the practicum site will represent the student as a psychologist. The site or the student will inform clients that the graduate student is providing services as part of professional training.

The site is in compliance with APA Ethical Principles of Psychologists and APA Standards for Providers of Psychological Services.

Supervisor name: ________________________________

Supervisor signature: ________________________________

Licensed psychologist’s name, if supervisor is not a licensed psychologist: __________

Licensed psychologist’s signature: ________________________________

Date: ______________

Approval from current Director of Clinical Training:

DCT’s name: Nicholas Allen, PhD

DCT’s signature: ________________________________

Date: ______________