INTERNSHIP FACILITY INFORMATION FORM

A. Name of Student: ____________________________________________________
   Beginning and ending dates of placement: ________ to ________
   Placement: ________ First (  ) Second (  ) Third (  )

B. Name of Facility: ____________________________________________________
   Population: _________________________________________________________

C. BC-DMT Supervisor: __________________________________________________
   Additional Credentials: _____________________________________________
   Employed by: (  ) Facility   (  ) DMT Program   (  ) Other, please explain:
   ___________________________________________________________________

D. Student Time at Facility: (If available, include weekly schedule.)

<table>
<thead>
<tr>
<th>Days per week:</th>
<th>Hours per week:</th>
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<tbody>
<tr>
<td>Number of weeks:</td>
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   Total Number of Hours:

   Total DMT Session Hours:

   Total Patient Contact Hours per week (including DMT):

   Staff meetings, hours per week:

E. Supervision:

   What form(s) of supervision are provided (i.e., individual or group, in session or post session, videotape)?
   ___________________________________________________________________

   How many hours of supervision are provided each week? ________________

   What is the total number of supervision hours provided? ________________

   70 hours of supervision provided by (check more than one, if applicable and include number of hours):

   _____ a BC-DMT credentialed supervisor employed at clinical site
   _____ a BC-DMT credentialed supervisor at the academic institution
   _____ another BC-DMT credentialed supervisor, please explain: