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.)

Days per week:	
Hours per week:	
Number of weeks:	
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: