TRINITY WESTERN UNIVERSITY | MA COUNSELLING PSYCHOLOGY

Name: _____

Date: _____

GROUP EXPERIENCE FORM – Section 1: Application

Group experience must occur in the context of internship or practicum and must be documented on your log of hours sheet as well as on this group experience form. If you wish to facilitate a group **not** sponsored/run by your contracted internship/practicum setting, you must obtain permission from a member of the Clinical Team. You are responsible to arrange for supervision by a supervisor approved by the Clinical Team. This supervisor must provide a brief evaluation on your skills (see Section 2) and then you should discuss the experience with your regular practicum/internship supervisor.

Section 1: Please fill out and submit this form for approval to Clinical Team.
Approval must be granted by the Clinical Team before the group begins.

Workshop Title:_____

Purpose of the Group (group goal): _____

OR Building Healthy Relationships Workshop ☐ Basics of Healthy Relationships

☐ Couples Communication

Location of Workshop: _____

Date(s) of Workshop: _____

Number of participants_____ Number of Direct Group Hours _____

Give a brief description of your role in this group: _____

_____

On-Site Supervisor's Name & Phone*:_____

_____

***If supervisor is new to CPSY, please fill out page 3.**

Approved by Clinical Team member**:_____

****Permission & signature required *prior to* group starting.**

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Name: _____

Date: _____

GROUP EXPERIENCE FORM – Section 2: Feedback

Section 2: This section should be filled out AFTER the group experience has taken place and must be handed in to the Clinical Team (please keep a copy for your records).

Evaluation (provided by on-site supervisor & discussed with your practicum/internship supervisor)

Student's willingness to receive feedback/supervision:

_____

Student's strengths as a facilitator/presenter:

_____

Student's basic therapy skills (joining, etc.):

_____

Student's area(s) of growth as a facilitator/presenter:

_____

Student's ethical behavior and compliance with agency policy:

_____

Student's overall performance (1 = very poor, 7 = very good):

1 2 3 4 5 6 7

Other Comments:

_____

_____

	(Print Name)	(Sign Name)	(Date)
Student:	_____	_____	_____
Group Supervisor:	_____	_____	_____
Clinical Team Member:	_____	_____	_____

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PROFESSIONAL BACKGROUND FOR ON-SITE CLINICAL SUPERVISORS

*(To be submitted by the student to a prospective on-site clinical supervisor, completed and signed by the prospective supervisor, and submitted to a Clinical Team Coordinator by the student **prior to** completing an agreement with a site)*

1. Degree (*minimum requirements are a Master's degree in a mental health/counselling profession, and the equivalent of five years post-masters full-time professional experience*)

☐ MD	☐ MA	☐ MTS-C
☐ PsyD	☐ MSc	☐ MSN
☐ PhD	☐ MSW	☐ Other ( )

2. Degree-granting institution & date of completion:

3. Post-masters Professional Experience [FTEs, full-time equivalents]

   Number of years:
   Work Responsibilities:

4. Post-masters Supervision Experience

   Number of years:
   Supervisee's training program(s):

5. a) Professional Credentials (e.g., CCC, RCC, etc.) and professional memberships (e.g., CCPA, BCPA.):

   _____

   b) Province/territory & college granting credentials (for regulated professions):

   _____

   c) Registration Number: _____

I _____ of _____
(Name) (Site)

hereby certify that the above information is complete and accurate.

Signature: _____ **Date:** _____