REQUEST TO EXTEND CLINICAL EXPERIENCE BEYOND PRACTICUM

Student Name _____

Current Practicum Site _____

Date Practicum Terminates _____

Purpose of extension

_____

Number of clients for whom services will be continued: _____

Name of direct supervisor who will provide supervision beyond practicum:

_____

Is this supervisor licensed as a psychologist in the State of Florida? _____

Is this different supervisor than previously assigned at this site? _____

Other relevant information:

_____

_____ _____

Student Signature Date Program Director or Agency Contact Date

_____ _____

Supervisor Signature Date Site Director Date

Additional conditions of approval:

_____

_____

This extension will expire on: _____

Approved by: Director of Clinical Training Date