McGill University
School/Applied Child Psychology
INTERNSHIP PLACEMENT FORM

This form is to be completed by the individual(s) who will assume direct supervision of or responsibility for the internship of the student named below. This form must be submitted to the Director of Clinical Training for approval.

Name of Student: _____

Placement: _____

Address: _____

Telephone: _____ Fax: _____

Name(s) of the person(s) who will supervise or assume responsibility for the student's internship: (Please print clearly)

Supervisor's Name	Phone	Email

Nature of the duties of this student's internship: _____

_____

Number of days per week this student will be involved in the above duties: _____

_____

Days and times that the student will be required at his or her internship site (e.g., supervision, department grand rounds, team supervision, etc.):

_____

_____

Signature of person completing this form: _____

Date: _____