Form G: Verification of Supervised Clinical Work:
Hours Certification and Final Evaluation
Oklahoma State University Counseling Psychology Program

Date: ____________________________

From (Include supervisor name, degree, professional licenses):

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Site: ____

To: OSU Counseling Psychology Program Core Faculty
c/o Julie Koch, Ph.D., Training Director

Re: Supervised Clinical Work of (Student's name):____________________________

This is to verify that the student completed the amount and types of clinical work experience hours indicated below during the following time period: _________________

1. Intervention & Assessment Experience	Program Sanctioned Hours		Hours
(Face to Face)		**G. Other Psychological Interventions**	
A. Individual Therapy		1. Sport Psych/Performance Enhancement	
1. Older Adults (65+)		2. Medical/Health-Related Interventions	
2. Adults (18-64)		3. Intake Interview/Structured Interview	
3. Adolescents (13-17)		4. Substance Abuse Interventions	
4. School-Age (6-12)		5. Consultation	
5. Pre-School Age (3-5)		6. Other Interventions	
6. Infants/Toddlers (0-2)		**H. Psychological Assessment Experience**	
B. Career Counseling		1. Psychodiagnostic test administration	
1. Adults		2. Neuropsych Assessment	
2. Adolescents		3. Other	
C. Group Counseling		**I. Other Psych Exp with Students &/or Org**	
3. Adults		1. Supervision of other students	
4. Adolescents (13-17)		2. Program Development/Outreach	
5. Children (12 and under)		3. Outcome Assessment of programs	
D. Family Therapy		4. Systems Intervention / Consultation	
E. Couples Therapy		5. Other	
F. School Counseling Interventions		**TOTAL INTERVENTION/ASSESSMENT (A-I)**	
1. Consultation			
2. Direct Intervention			
3. Other			

Activity	Program Sanctioned Hours
2. SUPPORT ACTIVITIES (Case Conf, Case Mgmt / Cons, Didactic Train/Seminars/Grnd Rnds, Progress Note/Clinical Wrtng /Chart Rev, Psych Assess Scoring/Interpret. Video-Audio-Digital Recording Review)	
3. Supervision Received	
A. Hours spent in one-on-one, face-to-face supervision	
i. Provided by Licensed Psych/Allied MH Prof	
ii. Provided by Adv Grad Stud Super by Lic Psy	
B. Hours spent in group supervision	
i. Provided by Licensed Psych/Allied MH Prof	
ii. Provided by Adv Grad Stud Super by Lic Psy	
TOTAL SUPERVISION HOURS	
TOTAL APPIC HOURS	

I further certify that during the above time period I provided ________________ hours of individual supervision and _________________ hours of group supervision.

Performance Evaluation: Strengths & Areas for Growth

At this time, I would say that clinical and/or professional strengths include:

At this time, I would like to see further development of the following clinical and/or professional skills:

Signature of supervisee: ____

Signature of supervisor with credentials: ________________________________