



Clinical Mental Health, CFT and School Counseling Programs

# New Site Approval Request Form

*Counselor-in- Training Name:*

*Email:*

**SITE INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**SUPERVISOR INFORMATION** *(please attach a copy of supervisor’s resume/vita to this form)*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Degree(s) [e.g., M.A. School Counseling, 2000, University of Northern Colorado]:

\_\_\_\_\_

\_\_\_\_\_

License/Credentials: \_\_\_\_\_

Years of experience as a School Counselor or Clinical Mental Health Counselor: \_\_\_\_\_

Number of Years at Current Position: \_\_\_\_\_ *(If less than 2 years at current position, briefly describe previous experience on the lines provided below)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_