Department of
PSYCHOLOGY

Queen's UNIVERSITY

Overview of Clinical Activities

Student Name: _____ **Date Submitted:** _____

Program Level (i.e. MSc2): _____

Timeline – From Term/Year: _____ **To Term/Year:** _____

We have reviewed the criteria for program-sanctioned hours, believe that the clinical experiences will meet the criteria, and commit to fulfilling these criteria throughout the period of clinical experiences. The student's signature acknowledges that the student's commitment to this clinical work has been discussed with their Research Supervisor and approved.

_____ _____
Student signature Date

_____ _____
Supervisor signature Date

Clinical/Research Supervisor Name				
Population seen i.e. adult, youth, families				
# of Direct Hours				
# of Support Hours				
# of Individual Supervision Hours				
TOTAL HOURS				
Clinical/Research Supervisor signature confirmation of completion of hours indicated above				
Clinical/Research Supervisor signature date				

Description of clinical activites to be completed/completed with each supervisor:

Supervisor #1 – Name: _____

Supervisor #2 – Name: _____

Supervisor #3 – Name: _____

Supervisor #4 – Name: _____

How the activities addressed a gap in my training

Indicate your primary reason for seeking out this placement:

List potential impacts of clinical experience on thesis research:

Submit completed/signed form to PSYC Graduate Office for filing in student's graduate file