Appendix K

Clinical Student Clerkship Agreement
University of Connecticut Psychological Sciences Department

Student Information

Name: ____________________________  Degree Program: Psychological Sciences - Clinical Psychology PhD

Faculty Supervisor: __________________ Email: __________________ Phone: ________________

Clinical Experience Site Information

Institution: ________________________________________________________________

Department: ________________________________________________________________

Site Supervisor (Fall): Site Supervisor (Spring or Add’l, if applicable):

Name: ____________________________  Name: ____________________________

Email: ____________________________  Email: ____________________________

Phone: ____________________________  Phone: ____________________________

Dates of Clinical Experience (mm/dd/yyyy): ____________ to ____________

Planned Schedule:

Days/Hours (fill in hours, i.e. 9:00am – 5:00pm for each day below):

Mon ________  Tues ________  Wed ________  Thurs ________  Fri ________

Total Expected Hours for Placement Experience: ____________

LEARNING ACTIVITIES: Describe what you expect to learn during this Clerkship (e.g., supervised experience in psychotherapy, psychological assessment, neuropsychological assessment, case consultation, expand or develop knowledge in a specific area, improve specific skills/competencies, etc):

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EVALUATION: Written evaluations shall be completed by the site supervisor two times during the experience. Evaluations must be based in part on direct observation of the student’s work.

REQUIRED SIGNATURES:

Clerkship Student:

I agree to abide by all policies and procedures of UConn and the Clinical Experience Site.

Signature: ____________________________  Date: ____________
**Clinical Experience Site Supervisor(s):** I agree to supervise the activities of this **Clerkship** student, provide ongoing feedback to the student and their faculty supervisor as requested, and complete evaluations as indicated above.

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