

Hours Form 1: Client Contact & Supervision Hours

TERM/YEAR _____ NAME OF INTERNSHIP SITE _____

Week		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total Hours
Date:																		
Client Contact Hours	Individual Counseling																	
	Couple Counseling																	
	Family Counseling																	
	Group Counseling																	
	TOTAL Client Contact Hours																	

Supervision	Individual Supervision																	
	Triadic Supervision																	
	Site-Group Supervision																	
	Campus- Group Supervision Class																	
	Telephone Supervision																	
	On-line Supervision																	
TOTAL Supervision Hours																		

Intern's Name _____ Signature _____ Date _____

Site Supervisor's Name _____ Signature _____ Date _____