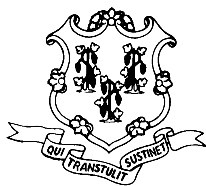

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF INTERNSHIP/PRACTICUM

This verification must be completed by the Program Director of the graduate degree program or postgraduate clinical training program. The completed form should be sent directly from the source to:

MFT Licensure
Department of Public Health
410 Capitol Ave., MS#12APP
P.O. Box 340308
Hartford, CT 06134-0308

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Name of Applicant: ____

Name and address of graduate program or postgraduate clinical training program:

____

____

____

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<u>If graduate program</u>:

Is program regionally accredited? Yes ☐ No ☐

Does program specialize in marriage and family therapy? Yes ☐ No ☐

<u>If postgraduate clinical training program</u>:

Is program approved by Commission on Accreditation for Marriage and Family Therapy Education?
Yes ☐ No ☐

Is program recognized by the U.S. Department of Education? Yes ☐ No ☐

****

How many months of actual supervised practicum or internship did the individual engage in? ______________

Dates the practicum or internship began and ended: From ______/______/______ To ______/______/_______

How many direct clinical hours did the individual engage in during the practicum or internship? ____________

How many hours of clinical supervision were provided to the individual during the practicum or internship? ____________

Program Director's Name (Please Print): ____

Signature of Program Director: ____________________________________ Date: _____/_____/_____