ASHLAND THEOLOGICAL SEMINARY
CLINICAL MENTAL HEALTH COUNSELING PROGRAM

PRACTICUM HOURS VERIFICATION

Student’s Name: ____________________________________________________________

I completed my 100 hours of practicum (of which _____ hours were direct service to clients) at:

__________________________________________________________________________

Name of Agency

__________________________________________________________________________

Address

__________________________________________________________________________

Date

Direct Service _________ (minimum of 40 hours required)

Indirect Service _________

Supervision _________ (minimum of 5 hours required; 1 hour per 20 hours)

TOTAL _________

Counselor Trainee’s Signature: ____________________________________________

Practicum Field Supervisor’s Printed Name: _________________________________

Practicum Field Supervisor’s Signature: _________________________________