

# SCSU Counseling Services

## Application for Training Positions

Name of Applicant: \_\_\_\_\_  
*Last* *First* *M.I.*

Address: \_\_\_\_\_  
*Street* *Unit #*

\_\_\_\_\_ *City* *State* *Zip*

Telephone: \_\_\_\_\_  
*Home* *Cell*

Email: \_\_\_\_\_

1. Graduate discipline:  Social Work  CMHC  MFT  
 Other (please specify \_\_\_\_\_)

Degree sought:  Master's  Doctorate

Years in program  Anticipated graduation date (month/year) \_\_\_\_\_

University \_\_\_\_\_

2. Have you ever been accused of violating any ethical or legal standards of behavior for counselors, social workers, MFTs or psychologists?  Yes  No

If yes, please describe:

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3. Previous Clinical Experience:

a. How many clients have you worked with in individual counseling?

1-10  11-20  21-30  31-40  41-50  50+

b. How many client contact hours do you estimate in individual counseling (number of clients x number of sessions)?

\_\_ 1-25 \_\_ 26-50 \_\_ 51-100 \_\_ 100+

c. How many counseling or support groups have you worked with? \_\_\_\_\_

d. How many contact hours do you have in group counseling (number of groups x number of sessions)? \_\_\_\_\_

e. Please describe any counseling-oriented group(s) you have facilitated or co-facilitated.

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f. Please list the client issues/concerns with which you have experience.

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g. Please describe any experience you have had working with diversity issues.

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h. Please describe your experience with career counseling and career assessment.

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i. Please describe your post-graduation career goals.

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*qualified individual who is extensively familiar with your clinical work. The information to be provided is part of your private education records, which are protected from unauthorized release by federal legislation. Therefore, you must give written authorization for this information to be released. Please sign your name in the space provided below to indicate your authorization.*

Name of Applicant (please print): \_\_\_\_\_

Position Applying For: \_\_\_\_\_

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

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**THE FOLLOWING IS TO BE COMPLETED BY THE PERSON PROVIDING THE REFERENCE:**

Name and Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Email: \_\_\_\_\_

INSTRUCTIONS: Please respond to the following items regarding the above named applicant:

1. Summarize the applicant's progress to date in the academic program.
2. Describe the applicant's response to supervisory relationships.
3. Describe the applicant's strengths in regard to clinical skills.
4. Describe the training needs of the applicant and indicate any deficits or difficulties that may exist in the applicant's skills. Indicate if you have any knowledge that the applicant has withdrawn from a practicum or internship or been forced to withdraw prior to completion.
5. Please describe the applicant's maturity level and professional demeanor.
6. Do you have any knowledge of any ethical or legal violation or complications concerning this applicant? Are you aware of any concern(s) about the emotional/mental fitness of this applicant to provide mental health services? If so, please describe.

Please return by application deadline **(March 15, 2016)** to:

**Elaine Allen, LCSW  
Training Coordinator**

**allene4@southernct.edu  
(203) 392-5475**

**SCSU Counseling Services  
Engelman 219 B  
New Haven, CT 06515**

**FAX (203) 392-5478**