

**STUDENT EVALUATION OF TRAINEESHIP**

*Please type or print legibly.*

MA-C  MA-D  MA-L

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Site \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

On-Site Supervisor \_\_\_\_\_ E-mail \_\_\_\_\_

Supervisor's License Number \_\_\_\_\_ Degree \_\_\_\_\_

Dates Covered by this evaluation: From \_\_\_\_\_ To \_\_\_\_\_

**GENERAL INFORMATION:**

**1. Type of Supervision Received:**

A. One-to-One, Individual: Hours per week \_\_\_\_\_

B. Group Supervision (8 trainees or fewer): Hours per week \_\_\_\_\_

C. Other (Specify): \_\_\_\_\_ Hours per week \_\_\_\_\_

**2. Supervision Approach:**

A. Case Report \_\_\_\_\_

B. Audio Tape \_\_\_\_\_

C. Video Tape \_\_\_\_\_

D. Direct Observation \_\_\_\_\_

E. Other (Specify) \_\_\_\_\_

**3. What type of counseling did you do at this site?**

(Please check those that apply and indicate a percentage of your total case load for each.)

Individual \_\_\_\_\_%  Couples \_\_\_\_\_%  Children \_\_\_\_\_%  Families \_\_\_\_\_%

Other \_\_\_\_\_% Please Specify \_\_\_\_\_

**4. What kinds of client problems did you work with at this site?** \_\_\_\_\_

\_\_\_\_\_

**5. Does this agency specialize in a specific type of client and/or problem?**

No  Yes Please specify \_\_\_\_\_

**GLOBAL EVALUATION OF TRAINEESHIP EXPERIENCE WITH THIS AGENCY:**

What did you find most personally meaningful in your traineeship?

What did you find most challenging or difficult, and why?

How did the traineeship contribute to your development as a clinician?

Please describe what you believe are the major strengths and major weaknesses of your traineeship experience (attach additional sheets as needed).

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Student's Signature

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Date

PLEASE RETURN TO:

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Telephone: 805.695.0555 • Fax: 805.695.0458 MA-C Track: Avrom Altman, M.F.T., L.P.C., Clinical Coordinator (ext. 24).  
MA-D & MA-L Tracks: Willow Young, M.A., M.F.T., Director of Clinical Training (ext 21)