

Clinical Placement Clinical Hours Summary

1. To be completed by the student at the end of the clinical placement term and signed by the **Clinical Supervisor**.
2. The **student** will email the **original soft copy** to the Program Coordinator (cc: clinical-psych@utsc.utoronto.ca) within two weeks of the placement end date.

*****DOWNLOAD AND SAVE A COPY OF THIS FORM BEFORE COMPLETING*****

General Information			
Student Full Name		Student Number	
Student Email		Today's Date	
Placement Start Date (mm/dd/yyyy):		Placement End Date (mm/dd/yyyy):	
Clinic Name		Organization	
Clinical Site Director Name (Training Program)		UTSC Course <input type="checkbox"/> CPS1803H <input type="checkbox"/> CPS3999H <input type="checkbox"/> CPS6999H	<input type="checkbox"/> CPS2999H <input type="checkbox"/> CPS4999H <input type="checkbox"/> CPS7999H
Clinical Supervisor Name and Degree/Qualifications		<input type="checkbox"/> CPO Licensed Psychologist <input type="checkbox"/> Licensed Psychologist Elsewhere <input type="checkbox"/> Other Licensed Professional <input type="checkbox"/> Not Licensed	
Clinical Supervisor Email		Clinical Supervisor Office Telephone	
Clinical Co-Supervisor Name and Degree/ Qualifications (if applicable)		<input type="checkbox"/> CPO Licensed Psychologist <input type="checkbox"/> Licensed Psychologist Elsewhere <input type="checkbox"/> Other Licensed Professional <input type="checkbox"/> Not Licensed	
Clinical Co-Supervisor Email		Clinical Co-Supervisor Office Telephone	

Training Site

Description - Describe the nature of training including target population, clinical activities, and learning outcomes.

Setting (check all that apply):

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Community Mental Health Center | <input type="checkbox"/> University Counseling Centre | <input type="checkbox"/> Residential/Group Home | <input type="checkbox"/> Inpatient Psychiatric Hospital |
| <input type="checkbox"/> Medical Clinic/Hospital | <input type="checkbox"/> Outpatient Psychiatric Clinic/Hospital | <input type="checkbox"/> Partial Hospitalization/ Intensive Outpatient | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> School | <input type="checkbox"/> Forensic/Justice Setting | <input type="checkbox"/> Child Guidance Clinic | |

Other (specify): _____

Primary Theoretical Orientation (select up to 3):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Behavioural | <input type="checkbox"/> Biological | <input type="checkbox"/> Cognitive Behavioural | <input type="checkbox"/> Eclectic |
| <input type="checkbox"/> Interpersonal | <input type="checkbox"/> Integrative | <input type="checkbox"/> Humanistic/Existential | <input type="checkbox"/> Psychodynamic/ Psychoanalytic |
| <input type="checkbox"/> Systems | <input type="checkbox"/> Other (specify): | | |

Supervision Hours

	Individual (regular schedule, one-on-one, face-to-face)	Group (regular schedule, face-to-face, multiple trainees)
Licensed Psychologist		
Licensed Allied Mental Health Professional		
Other Supervision		
Total Supervision Hours (Individual + Group)		

Supervision Format (check all that apply):

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Audio Tape | <input type="checkbox"/> Video Tape/Digital Recording | <input type="checkbox"/> Live/Direct Observation by Supervisor |
|-------------------------------------|---|--|

Intervention Experience			Total Hours (face-to-face)	No. of Different Individuals (groups, families couples)
Individual Therapy	Older Adults (+65)			
	Adults (18-64)			
	Adolescents (13-17)			
	School-Age (6-12)			
	Pre-School Age (3-5)			
	Infants/Toddlers (0-2)			
Career Counseling	Adults			
	Adolescents (13-17)			
Group Counseling*	Adults			
	Adolescents (13-17)			
	Children (12 and under)			
Family Therapy				
Couples Therapy				
School Counseling Interventions	Consultation			
	Direct Intervention			
Other Psychological Interventions	Sport Psychology/Performance Enhancement			
	Medical/Health Related Interventions			
	Intake Interview/Structured Interview			
	Substance Abuse Interventions			
	Consultation			
	Other Interventions (e.g., milieu therapy, treatment planning with patient present)			
Other Psychological Experience	Supervision of other students			
	Program Development/Outreach Programming			
	Outcome Assessment			
	Systems Intervention/Organizational Consultation/Performance Improvement			
	Other (specify):			
Total Intervention Hours				

*NB: When documenting clinical hours, a group should be thought of as a single "unit". For example, suppose you are leading a 2-hr weekly therapy group for social anxiety and the group consists of 12 clients. The number of intervention hours per week is equal to 2 hours, regardless of number of clients in your group or the number who attend each week. This same guidelines applies to other multi-person modalities (eg family therapy and couple therapy).

Psychological Assessment			Total Hours (face-to-face)	No. of Different Individuals
Psychodiagnostic Test Administration	Symptom assessment, projectives, personality, objective measures, achievement, intelligence, career assessment, providing feedback			
Neuropsychological Assessment	Multiple cognitive, sensory, and motor functioning (include intellectual assessment only when in context of neuropsych)			
Other (specify):				
Total Assessment Hours				

Number of Reports	
Integrated Psychological Reports (synthesized comprehensive report including history, interview, and at least two standardized tests)	

TOTAL DIRECT HOURS (Intervention + Assessment)	
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Diversity Experience			
<i>Indicate when known</i>		Intervention (No. of clients)	Assessment (No. of clients)
Race/Ethnicity/ Cultural Background	Black (e.g., African, Haitian, Jamaican, Somali, etc.)		
	Asian		
	East Asian (e.g., Chinese, Japanese, Korean)		
	South Asian (e.g., East Indian, Pakistani, Bengali, Sri Lankan, etc.)		
	Southeast Asian (e.g., Filipino, Vietnamese, Indonesia, Malaysian, Singaporean, etc.)		
	West Asian (e.g., Iranian, Afghan, etc.)		
	Latin American		
	Indigenous/First Nations/Inuit/ Métis		
	European Origin/White		
	Mixed ethnic heritage/Multiracial		
	Other		
	Arab		
	Individually defined		
Sexual Orientation	Heterosexual		
	Gay		
	Lesbian		
	Bisexual		
	Pansexual		
	Other / As individually defined		
Disabilities	Physical / Orthopedic Disability		
	Blind / Visually Impaired		
	Deaf / Hard of Hearing		
	Learning / Cognitive Disability		
	Developmental Disability		
	Serious Mental Illness (e.g. psychosis, major mood disorder)		
	Other		
Gender	Male		
	Female		
	Trans*		
	Other / As individually defined		

		Intervention (No. of clients)	Assessment (No. of clients)
Language	French (Francophone)		
	English (Anglophone)		
	Other		
Faith	Catholic		
	Protestant		
	Other Christian (e.g. Orthodox Christian)		
	Muslim		
	Jewish		
	Hindu		
	Sikh		
	Buddhist		
	Atheist / No religion affiliation		
	Agnostic		
Other / As individually defined			

Indirect Clinical Hours		
		Total Hours
Intervention	Chart review, Video/Audio review, Session planning, Reading	
	Writing: Progress notes, Intake, Discharge/Termination	
	Scoring, interpretation assessment measures	
	Observation of another's therapy session	
	Other (e.g. phone calls, case management)	
Assessment	Chart review, Video/Audio review, Session planning, Readings	
	Scoring, interpretation assessment measures	
	Writing: Assessment reports	
	Observation of another's assessment	
	Other (e.g. phone calls, case management)	
Total Indirect Clinical Hours		

Additional Training	
	Total Hours
Case Conferences	
Grand Rounds	
Clinical Seminars (didactics, lectures, instruction, demonstration)	
Team/Unit/Ward Meetings (non-supervision)	
Research	
Other:	
Total Additional Training Hours	

Assessment Instruments			
Diagnostic Interview Protocols	No.	Academic Functioning	No.
SADS		Strong Interest Inventory	
SCID		Wechsler Individual Achievement Test (WIAT)	
DIS		Wide Range Assessment Memory & Learning	
Other:		Woodcock Johnson III	
General Intelligence Measures Assessment		WRAT-4	
Stanford-Binet 5		Other:	
TONI-3		Behavioural and Personality Inventories	
WAIS IV		Millon Clinical Multi-Axial III (MCMI)	
Other:		Minnesota Multiphasic Personality Inventory	
Projective Assessment		Myers-Briggs Type Indicator	
Human Figure Drawing		Personality Assessment Inventory	
Kinetic Family Drawing		Beck Depression Inventory	
Sentence Completion		Beck Anxiety Inventory	
Thematic Apperception Test		Hamilton Depression Scale	
Rorschach		Adult Manifest Anxiety Scale	
Other:		Performance and Symptom Validity Measures	
Neuropsychological Assessment		Structured Interview of Reported Symptoms	
Boston Diagnostic Aphasia Exam		Miller Forensic Assessment of Symptoms Test	
Brief Rating Scale of Exec Fxn (BRIEF)		Rey 15-Item Test	
Dementia Rating Scale II		Test of Memory Malingering (TOMM)	
California Verbal Learning Test		Victoria Symptom Validity Test	
Continuous Performance Test		Validity Indicator Profile	
Delis Kaplan Executive Function System		Forensic and Risk Assessment	
Finger Tapping		Psychopathy Checklist-Revised; Static 99	
Grooved Pegboard		Violence Risk Assessment Guide	
Rey-Osterrieth Complex Figure		History-Clinical-Risk 20	
Trailmaking Test A & B		Other:	
Wechsler Memory Scale IV			
Wisconsin Card Sorting Test			
Behavioural Assessment of the Dysexecutive Syndrome			
Benton Facial Recognition Test			
Benton Judgment of Line Orientation			
Boston Naming Test			
Brief Test of Attention			
Brief Visuospatial Memory Test – Revised			
Comprehensive Trail Making Test			
Hopkins Verbal Learning Test – Revised			
Kaplan Baycrest Neurocognitive Assessment			
Ruff 2&7 Selective Attention Test			
Symbol Digit Modalities Test			

TOTAL HOURS COMPLETED DURING THIS PRACTICUM: _____
(Sum of Total Supervision Hours, Total Direct Hours, Total Indirect Clinical Hours and Total Additional Training)

We, the undersigned, certify that all of the clinical hours information presented above was completed under supervision and is true to the best of our knowledge.

Clinical Supervisor Signature **Clinical Supervisor Name PRINT** **Date**

Clinical Co-Supervisor Signature **Clinical Co-Supervisor Name PRINT** **Date**
(if applicable)

Student Signature **Student Name PRINT** **Date**

Program Coordinator Signature **Program Coordinator Name PRINT** **Date**

Please email soft copy to the Program Coordinator
(cc: clinical-psych@utsc.utoronto.ca)