

**Master of Arts in Counseling
Professional Practice Form**

INTERNSHIP Hours Summary Form

Student: _____

Site: _____

Activity	Summer ____	Fall ____	Spring ____	GRAND TOTAL
DIRECT CONTACT HOURS	# hours	# hours	# hours	
Individual Hours				
Coordinated Care - Individual Hours				
Co-located Care - Individual Hours				
Integrated Care - Individual Hours				
Counseling/Psychoeducational Group				
Coordinated Care - Group Hours				
Co-located Care - Group Hours				
Integrated Care - Group Hours				
Couples and/or Family Counseling				
Substance Abuse - Specific				
Total Direct Contact Hours:				

INDIRECT SERVICE HOURS	Summer ____	Fall ____	Spring ____	
Individual Site Supervision				
Site Group Supervision				
EMU Group Supervision				
Program Planning				
Consultation				
Interdisciplinary Team Meetings				
Interdisciplinary Consultation				
Conferences Attended				
Workshops Conducted				
Administrative Responsibilities				
Other				
Total Indirect Service Hours:				

SEMESTER TOTAL HOURS	Summer	Fall	Spring	
Site Supervisor Verification (Please initial):				
Faculty Supervisor Verification (Please initial):				
SEMESTER TOTAL HOURS (Direct + Indirect)				

Please sign below to verify the grand total of internship hours at the end of internship

Site Supervisor – Sign and Date

Faculty Supervisor – Sign and Date

Sign End of Internship