

**Quarterly Clinical Training Schedule**

**Student Information**

Name:       ID #       Contact Number:

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| Department: | ------- | Quarter: | -------- | Year: | ------- |

Degree: (check one): MA MS MSW DMFT PSYD PHD

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| Supervisor Name Contact Number |
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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

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Site Name/Location/Times Monday Tuesday Wednesday Thursday Friday

**Verification Signatures**

Applicant Date

Director of Clinical Training/Advisor Date

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Office use only:

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| Exempt |
| Non-exempt |

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Comments

Rev. 2/2013