

# Chatham University MSCP Field Placement Site Information Sheet

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Organization Name : \_\_\_\_\_

Type of program:

- |  |   |
|--|---|
| <input type="checkbox"/> Armed Forces Medical Center           | <input type="checkbox"/> Private School                     |
| <input type="checkbox"/> Child/Adolesent Psychiatric           | <input type="checkbox"/> School District                    |
| <input type="checkbox"/> Community Mental Health Center        | <input type="checkbox"/> State/County/Other Public Facility |
| <input type="checkbox"/> Prison or Other Correctional Facility | <input type="checkbox"/> Psychology Department              |
| <input type="checkbox"/> Private General Hospital              | <input type="checkbox"/> Residential Treatment Program      |
| <input type="checkbox"/> Private Outpatient Clinic             | <input type="checkbox"/> University Counseling Center       |
| <input type="checkbox"/> Private Psychiatric Hospital          | <input type="checkbox"/> Veterans Affairs Medical Center    |
|  | <input type="checkbox"/> Other _____                        |

Program or Facility Description:

Type of Population Served: (Check all appropriate boxes)

- |   |  |
|---|--|
| <input type="checkbox"/> Infant/Early Childhood           | <input type="checkbox"/> Ethnic Minorities               |
| <input type="checkbox"/> Children                         | <input type="checkbox"/> Spanish-speaking                |
| <input type="checkbox"/> Adolesents                       | <input type="checkbox"/> Deaf/Hearing-impaired           |
| <input type="checkbox"/> Adults                           | <input type="checkbox"/> Students/International Students |
| <input type="checkbox"/> Older Adults                     | <input type="checkbox"/> Rural                           |
| <input type="checkbox"/> Inpatients                       | <input type="checkbox"/> Urban                           |
| <input type="checkbox"/> Outpatients                      | <input type="checkbox"/> Low Income                      |
| <input type="checkbox"/> Gay/Lesbian/Bisexual/Transgender | <input type="checkbox"/> Homeless                        |
| <input type="checkbox"/> Other _____                      | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Other _____                      | <input type="checkbox"/> Other _____                     |

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Organization Name : \_\_\_\_\_

## Treatment Modalities: (Check all appropriate boxes)

- |   |   |
|---|---|
| <input type="checkbox"/> Individual Therapy     | <input type="checkbox"/> Play Therapy             |
| <input type="checkbox"/> Couples Therapy        | <input type="checkbox"/> Consultation/Liaison     |
| <input type="checkbox"/> Family Therapy         | <input type="checkbox"/> Crisis Intervention      |
| <input type="checkbox"/> Group Therapy          | <input type="checkbox"/> Brief Psychotherapy      |
| <input type="checkbox"/> Community Intervention | <input type="checkbox"/> Long-term psychotherapy  |
| <input type="checkbox"/> Behavioral Therapy     | <input type="checkbox"/> Cognitive rehabilitation |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> Other _____              |

## Specialty Areas: (Check all appropriate boxes)

- |   |   |
|---|---|
| <input type="checkbox"/> Health Psychology                    | <input type="checkbox"/> Trauma/PTSD                      |
| <input type="checkbox"/> Primary Care                         | <input type="checkbox"/> Substance Use Disorders          |
| <input type="checkbox"/> Women's Health                       | <input type="checkbox"/> Forensics/Corrections            |
| <input type="checkbox"/> HIV/AIDS                             | <input type="checkbox"/> Juvenile Justice/Corrections     |
| <input type="checkbox"/> Eating Disorders                     | <input type="checkbox"/> Sexual Offenders                 |
| <input type="checkbox"/> Sports Psychology                    | <input type="checkbox"/> Geropsychology                   |
| <input type="checkbox"/> Rehabilitation Psychology            | <input type="checkbox"/> Pediatrics                       |
| <input type="checkbox"/> Physical Disabilities                | <input type="checkbox"/> School                           |
| <input type="checkbox"/> Learning Disabilities                | <input type="checkbox"/> Counseling                       |
| <input type="checkbox"/> Developmental Disabilities           | <input type="checkbox"/> Vocational/Career Development    |
| <input type="checkbox"/> Sexual Disorders                     | <input type="checkbox"/> Multicultural Therapy            |
| <input type="checkbox"/> Assessment                           | <input type="checkbox"/> Feminist Therapy                 |
| <input type="checkbox"/> Early childhood/Infant Assessment    | <input type="checkbox"/> Religion/Spirituality            |
| <input type="checkbox"/> Neuropsychological - Adult           | <input type="checkbox"/> Empirically-Supported Treatments |
| <input type="checkbox"/> Neuropsychological - Child           | <input type="checkbox"/> Public Policy/Advocacy           |
| <input type="checkbox"/> Serious Mental Illness               | <input type="checkbox"/> Supervision                      |
| <input type="checkbox"/> Anxiety Disorders/OCD                | <input type="checkbox"/> Research                         |
| <input type="checkbox"/> Neurological Developmental Disorders | <input type="checkbox"/> Holistic Psychology              |
| <input type="checkbox"/> Other _____                          | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Other _____                          | <input type="checkbox"/> Other _____                      |

## Please Indicate Supervisors' Credentials: (Check all appropriate boxes)

- |   |  |
|---|--|
| <input type="checkbox"/> Ph.D                               | <input type="checkbox"/> MSW                             |
| <input type="checkbox"/> Psy.D                              | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Licensed Psychologist              | <input type="checkbox"/> Master of Science in Nursing    |
| <input type="checkbox"/> M.A./M.S                           | <input type="checkbox"/> ARNP/CRNP                       |
| <input type="checkbox"/> Licensed Professional Counselor    | <input type="checkbox"/> Certified School Psychologist   |
| <input type="checkbox"/> Licensed Marriage/Family Therapist | <input type="checkbox"/> Certified School Counselor      |
| <input type="checkbox"/> Certified Addiction Counselor      | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Other _____                        | <input type="checkbox"/> Other _____                     |

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Please provide organization contact information:

Organization Name: \_\_\_\_\_

Appointed Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_

Would your organization be willing to provide field placement training experiences to doctoral level students?  Yes  No

Are there any expenses which must be absorbed by the student?  Yes  No

If yes please indicate the purpose and estimate the expense.

Please Name all current supervisors and identify their degree and credential:

Name	Degree and Credential
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____