**Petition for Additional Clinical Training Site**

* ***This Petition is used by students who are providing therapy under supervision at a clinical training site, and who are requesting permission to provide therapy under supervision at an additional site.***
	+ *To request permission for an additional clinical site, students should be in good academic standing.*
	+ *This form should be used only with clinical training sites that have been previously approved by the MFT Director of Clinical Education.*
	+ *To seek approval for a new site, use the Petition for Program Approval of New Clinical Training Site form.*
* *A student may not provide therapy at any additional site until the MFT Director of Clinical Education has signed this petition.*

 **IDENTIFYING DATA - STUDENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name: |   | Today’s Date: |  |
| Telephone: |   | UVU Email: |  |
| Program CGPA: |  | *Are you in good standing with UVU?* | Yes | No |
| Total Therapy Hours: |  | *Do you have Satisfactory status with the MFT program?* | Yes | No |
| Relational Hours: |  | *Do you have a B or better grade in all current courses?* | Yes | No |

**IDENTIFYING DATA – CURRENT CLINICAL TRAINING SITE**

|  |  |  |  |
| --- | --- | --- | --- |
| Site Name: |   | Telephone: |  |
| Supervisor Name: |   | Supervisor Email: |  |
| *How many hours per week are you providing therapy at this site?* |  |
| *How many clients are you currently working with at this site?* |  |
| *Have you told this supervisor about your plan to take on an additional training site?* | Yes | No |
| *Is your current supervisor supportive of your plan to take on an additional training site?* | Yes | No |

**IDENTIFYING DATA – POTENTIAL ADDITIONAL CLINICAL TRAINING SITE**

|  |  |  |  |
| --- | --- | --- | --- |
| Site Name: |   | Telephone: |  |
| Supervisor Name: |   | Supervisor Email: |   |
| *Has this Clinical Training Site been approved by the MFT Program?* | Yes | No |
| *Does this supervisor know about your current clinical training site?* | Yes | No |
| *How many hours per week are you planning to provide therapy at this site?* |  |
| *What is your plan to manage your time and responsibilities at both sites?* |

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Trainee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Director of Clinical Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return this completed form to: UVU MFT Director of Clinical Education**