North Carolina State University
Counselor Education Program
Counseling Practicum Summary Sheet
(circle one)

Student Name__________________________Semester/Year:____________________
Concentration:_____________________________
Site Supervisor:__________________University Supervisor:____________________

Part I. Practicum Hours
1. Total hours of direct service:__________
2. Total hours of indirect service:__________

Part II. Practicum Services
A. Direct Service Hours
1. Total number of clients seen for individual counseling:__________
2. Number of individuals seen once: __________
   Twice: __________
   Three times: __________
   Four times: __________
   Five times: __________
   Six times: __________
   More than six __________
3. Number of group counseling sessions: __________
4. Number of Parent and Family Counseling Sessions __________
5. Number of Classroom Guidance or Psycho-educational Groups __________

B. Indirect Service Hours
6. Number of hours of Professional Development Activities attended. __________
   (i.e. Any professional programs, presentations, or in-services you attended. Briefly describe.)
   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

7. Number of hours of Consultation __________
8. Number of hours of Program Development __________
9. Number of hours of Assessment (Discuss the names of kinds of Assessment, i.e. IEP or specific kinds of tests) __________

10. Number of hours of Case Management __________

Part III. Supervision:
To be completed by Doctoral Student Supervisors, Site Supervisors, and Students for Practicum and by Site Supervisor, University Supervisor, and Student Intern for Internship.
Total Hours of Individual Supervision: Site ________ University ________ Total ________
Total Hours of Triadie Supervision: Site ________ University ________ Total ________
Total Hours of Group Supervision: Site ________ University ________ Total ________
Number of video tapes turned in by student: Site_______ University_______ Total_______
Number of video tapes critiqued in individual supervision:
Site_______ University_______ Total_______

Signing below indicates you have reviewed the information provided and it is accurate to the best of your knowledge.

Student Signature and Date:________________________________________
Site Supervisor Signature and Date:__________________________________
University Supervisor Signature and Date:______________________________