**Department of Counseling & Educational Psychology**  
**Mississippi State University**

**Master’s Internship Application***

Student Name: __________________________________________

**The following courses must be completed before applying for Internship.**

<table>
<thead>
<tr>
<th>Course</th>
<th>Semester Completed</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>COE 8013 - Counseling Skills</td>
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<tr>
<td>COE 8023 - Counseling Theory</td>
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<tr>
<td>COE 8043 - Group Tech &amp; Procedures</td>
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<tr>
<td>EPY 8263 - Psychological Testing</td>
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<tr>
<td>COE 8053 - Practicum*</td>
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</table>

**Appropriate Specialty Area Course:**

<table>
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<tr>
<th>Course</th>
<th>Semester Completed</th>
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</thead>
<tbody>
<tr>
<td>COE 8703 - Community Counseling</td>
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<tr>
<td>COE 6393 - Voc. Rehab Counseling</td>
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<tr>
<td>COE 8903 - School Counseling</td>
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<tr>
<td>COE 8553 - Student Affairs in Higher Ed.</td>
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</table>

*Note: Students must complete the practicum prior to the semester in which the internship is scheduled.*

Deadline for all fieldwork applications: The first day of classes

**Please Return Completed Application to:**

**Clinical Coordinator**  
**Department of Counseling & Educational Psychology**  
**Box 9727, 508 Allen Hall**  
**Mississippi State, Mississippi 39762-5740**  
**Fax: 662-325-3263**
MASTER’S INTERNSHIP APPLICATION

Note: Academic Advisor’s approval and signature must be obtained after you have your on-site supervisors signature. BOTH signatures MUST be on the application as well as a FULL mailing address to your site supervisor. Do not begin collecting hours until application is approved. INCOMPLETE APPLICATIONS WILL BE RETURNED. Please see the Graduate Student Handbook for further information.

Name: ________________________________ Date: __________

Address: ________________________________

City, State, Zip: ________________________________

Home Telephone: __________________________ Office Telephone: __________________________

E-Mail Address: ________________________________

Specific Dates of Collection of Internship Hours: **(Must be completed)**

Beginning: __________________________, 20_____ Ending: __________________________, 20_____ 

List the term you will register for the course: __________________________ 20_______

Site Information

(This must be a complete mailing address that is legible, if not you will not be approved)

Name of Site: ________________________________

Address: ________________________________

City, State, Zip: ________________________________

Telephone Number: ________________________________

Site is outside a 50-mile radius of Mississippi State University? Yes ☐ No ☐

If “Yes” you need to complete an “Approval Form to Receive Both Individual and Group Supervision on Site”.

Please Return Completed Application to:

Clinical Coordinator
Box 9727, 508 Allen Hall
Mississippi State, MS 39762-5740
Fax: 662-325-3263
On-Site Supervisor Information

On-Site Supervisor: ___________________________ Title: ___________________________

Address: (if different) ___________________________________________________________

City, State, Zip: ________________________________________________________________

Telephone Number: ___________________________ E-Mail Address: ______________________

On-Site Supervisor's Graduate Degrees(s): _______________________________________

Number Years of Relevant Post Masters Experience __________________________

On-Site Supervisor's Credentials: NCC ☐ CCMHC ☐ CRC ☐ LPC ☐ School Counselor Cert ☐

Other ☐ ___________________________ (Please specify)

Note: All supervisors must submit a resume and have a minimum of two years post-Masters experience. By signing below, on-site and academic supervisors certify the possession of the required credentials.

In addition:
School Counseling Supervisors must be Licensed School Counselors
Rehabilitation Counseling Supervisors must be CRC Certified
Community Counseling Supervisors licensed as Professional Counselors are preferred
Student Development Supervisors must have experience in an area of specialization compatible with students interests

On-Site Supervisor Signature ___________________________ Date ___________________________

Academic Advisor's Signature ___________________________ Date ___________________________

Coordinator's Signature ___________________________ Date ___________________________

☐ Approved ☐ Denied

Reason(s) for Denial: ____________________________________________________________

Note: Placement may begin only after the coordinator and your academic advisor have signed the application. Total hours must be completed before the term ends in which you register for the course. Students must submit documentation of liability insurance prior to collection of hours. For more information, contact academic advisors. Please list insurance information below.

Name of Company: ____________________________________________________________

Coverage Dates: ______________________________________________________________

Form modified October, 2007