Phillips
Graduate Institute
Master of Marriage and Family Therapy

For Office Use Only

Approved________________ Date__________

Not Approved ____________ Date__________

Approval Pending _________ Date _________

Date Processed __________________________

NOTIFICATION OF CLINICAL PLACEMENT

Due within 2 weeks of acceptance

STUDENTS MUST HAVE MALPRACTICE INSURANCE THAT INCLUDES CAMPBELLSVILLE UNIVERSITY AS AN ADDITIONAL NAMED INSURED. This placement will not be approved until the student provides evidence of Malpractice Insurance. Contact AAMFT or CAMFT for Malpractice Insurance. See *Clinical Training and Placement Handbook* page 21 for more information.

Student agrees to defend, indemnify, and hold harmless the Phillips Graduate Institute, Los Angeles Education Center of Campbellsville University and its officers, employees, and agents, from all acts, claims, liabilities, costs, expenses, and losses (including reasonable attorney's fees), or claims for injury or damage (collectively **"Claims")** by whomever asserted arising out of Student's performance of services during Clinical Placement, but only in proportion to and to the extent such Claims are caused by or result from the negligent or intentional acts or omissions of the Student.

Student's Name ____________________________________ Current Term __________________
PLEASE PRINT SEMESTER

Practicum Course Enrolled in: ☐ MFC 523 ☐ MFC 529 ☐ MFC 533 ☐ MFC 535 ☐ MFC 596

Name of Agency/Treatment Program____

Address ____

City ________________________________ Zip Code ____________ Phone ________________

Clinical Director ____
NAME DEGREE LICENSE#

Primary Supervisor ____
NAME DEGREE LICENSE#

____
PHONE EMAIL

Does the agency lawfully and regularly provide mental health counseling/psychotherapy? ☐ Yes ☐ No

Student will be scheduled ______ hours per week. The student will average _____ hours of direct client care. Student will receive _____ hour(s) of ☐ individual and/or ☐ group supervision per week. The student will be a ☐ volunteer or ☐ paid employee and begins on ____/____/____ and will end ____/____/____.

Student Signature ____ Date ______________

Agency Representative's Signature __________________________________ Date ______________

Phillips Clinical Training Office Signature ____________________________ Date ______________

Return completed form with proof of malpractice insurance
to the Clinical Training and Placement Co-Director(s)

Los Angeles
Education Center
OF CAMPBELLSVILLE UNIVERSITY