

# Extern Application Face Sheet

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Email (non-school): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Last 4 of SS# (123-45-\*\*\*\*): \_\_\_\_\_

DOB: \_\_\_\_\_ Pronoun/s: \_\_\_\_\_

Bilingual:  Yes  No If yes: (Language) \_\_\_\_\_

Graduate University: \_\_\_\_\_

Graduate Program: \_\_\_\_\_

Which degree are you seeking?  PhD  PsyD

Year in graduate program by externship start date: \_\_\_\_\_

Name of Director of Clinical Training in Graduate Program: \_\_\_\_\_

Director Email: \_\_\_\_\_

Will you have a master's degree by the start of the externship?  Yes  No

How many hours per week are you hoping to be at CHCO for externship? \_\_\_\_\_

Which externship track/s are you applying for at CHCO (check all that apply)?

- Child Clinical, Anschutz Medical Campus
- Child Clinical, Colorado Springs Network of Care
- Child Clinical Anxiety and OCD Focus, Highlands Ranch Network of Care
- Cystic Fibrosis, Anschutz Medical Campus
- Developmental Pediatrics, North Campus Network of Care and Anschutz Medical Campus
- Developmental Pediatrics Bilingual Track, Anschutz Medical Campus and/or Networks of Care
- Developmental Pediatrics, Pediatric Behavior Clinic, Anschutz Medical Campus and/or Networks of Care
- Gastroenterology, Anschutz Medical Campus
- Integrated Behavioral Health, Colorado Springs
- Neuropsychology, Anschutz Medical Campus and/or Networks of Care
- Pediatric Rehabilitation Psychology, Anschutz Medical Campus
- Transplant & Urology, Anschutz Medical Campus
- Young Mother's Clinic, Anschutz Medical Campus

### Supplemental Form

How many total neuropsychological assessments have you completed for youth under age 18? \_\_\_\_\_

How many total psychological assessments have you completed for youth under age 18? \_\_\_\_\_

Please list the number of assessments you have independently administered:

Intelligence measures	Clinical evaluations	Research evaluations
WISC-V		
WISC-IV		
WPPSI-IV		
WAIS-IV		
DAS-II		
Other:		
Achievement measures		
WIAT-4		
WJ-IV		
Other:		

Please complete the following table of how many total hours of direct therapy you have provided for youth in each of the following age ranges:

Individual Therapy	Total Hours Face to Face:	# of different individuals:
Adolescents (13-17)		
School-Age (6-12)		
Pre-School Age (3-5)		
Infants/Toddlers (0-2)		

In what settings have you previously seen youth for therapy? (i.e., community mental health, department clinic, hospital, school, residential/group home, outpatient clinic):

Have you co-led any groups for youth under age 18 or their parents? If so, which group(s) do you have experience with?

#### Professional Experience:

Previous practicum/externship experience:

Site:	Supervisor:	Dates:	Hours per week:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____