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?

<u>Professional Experience:</u>

Previous practicum/externship experience:

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