MARRIAGE AND FAMILY THERAPY PROGRAM

EVALUATION OF OFF-CAMPUS INTERNSHIP SITE

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ On Site Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To assess the effectiveness of your off-campus internship experience, please answer the questions below and make ratings where indicated using this scale:

1 = inadequate, 2 = partly adequate, 3 = adequate, 4 = good, 5 = outstanding

\_\_\_\_\_ 1. Overall effectiveness rating of site/ experience

\_\_\_\_\_ 2. Number and availability of cases

What type (individual, family, groups, typical problems, consistency in keeping appointments):

Population served:

\_\_\_\_\_ 3. On-site supervision

\_\_\_\_\_ Individual

\_\_\_\_\_ Group

Describe the type (e.g. live, video, audio, etc.)

Time in supervision weekly/ how available is it?

Co-therapy available?/ observing others doing therapy?

\_\_\_\_\_ 4. Coordinating with faculty supervision

\_\_\_\_\_ 5. Orientation (to clinic, with supervisor)?

\_\_\_\_\_ 6. Consultation with staff/ involvement with staff.

\_\_\_\_\_ 7. Facilities (adequacy of session rooms, videotaping available, one-way screens, etc.)

Transportation to and from site:

\_\_\_\_\_ 8. Contribution to your growth as a family therapist.

COMMENTS (about administration aspects and design of internship, what you found most valuable, suggestions for improvements):