

## Practicum Description for RCT-Candidacy Application

Name of Counselling Intern: \_\_\_\_\_

Course Number and Title of Practicum: \_\_\_\_\_

Name of agency/institution where practicum took place \_\_\_\_\_

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

Name of onsite supervisor, position, professional qualifications and phone number : \_\_\_\_\_

Period and duration of practicum (beginning and ending dates), distribution of hours per week. \_\_\_\_\_

Total number of hours of practicum	Total Number of Hours of <u>direct client contact</u> : <i>(minimum of 120 hours is required in this category)</i>	Time allotted for supervision (hours per week)
_____	_____	_____

**Type of Supervision:** (provide a quick point description of actual activities completed – an additional page can be used if required)

(a) **Direct** (direct observation, video-audio taped sessions, co-counselling) \_\_\_\_\_

(b) **Indirect** (case consultation, class meetings) \_\_\_\_\_

**Characteristics of client population** (age, milieu, typical presenting problems, etc): \_\_\_\_\_

**Summary of professional activities in which counselling intern participated in practicum** (indicate proportion of hours,/days, time devoted to each activity): \_\_\_\_\_

- This form can be completed by the applicant but it must be signed and forwarded to the NSCCT Registrar by the practicum professor/supervisor of the University where the training took place. If the professor is not available, the signature of the onsite supervisor is acceptable.
- If you cannot locate either your practicum professor or your practicum onsite supervisor, you will still need to complete this form but you will also need, in lieu of your supervisor's signature, a signed letter from the Head of the Counselling Faculty of the University from whence you graduated. This letter, provided on official University letterhead, must indicate that in your year of graduation, a student completing a practicum in Counselling at that university typically had a minimum of 120 hours of direct counselling contact with clients during his/her practicum.

**Supervisor's Name (printed):** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Professional Qualifications, degrees, certificates:** \_\_\_\_\_

**Phone # :** \_\_\_\_\_ **email:** \_\_\_\_\_

**Name of University Granting Applicant's Master's Degree:** \_\_\_\_\_

**Professor /Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail this form to:**  
NSCCT,  
36 Brookshire Court  
– Suite 201 –  
Brookshire Centre,  
Bedford, NS,  
B4A 4E9  
Questions?  
[registrar@nscct.ca](mailto:registrar@nscct.ca)  
  
**902-225-7531**