



Sacramento County
Department of Health Services
Division of Behavioral Health Services
STUDENT APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone: _____

I attest that I, _____, am a student at an accredited college or university participating in a field placement at this agency. I understand that I may provide services as an LPHA, with the exception of the privilege of co-signing for other staff, throughout this placement.

Name of College/University _____

- Medical Student Clinical Clerkship. I understand that all of my documentation must be co-signed by a psychiatrist.
Psychiatric Resident Unlicensed. I understand that all of my documentation must be co-signed by a psychiatrist.
Doctoral Level Student. I understand that all of my documentation must be co-signed by a licensed PHD or MD.
Master's Level Student. I understand that all of my documentation must be co-signed by an LCSW, LMFT, LPCC, PhD, or MD

My internship begins on _____ and ends on _____
Date Date

Clinical Supervisor's Name: _____ Discipline _____ License#: _____
Print Name

Student/Resident: _____ Date _____
Signature

Clinical Supervisor: _____ Date _____
Signature

Approval: Rolanda Reed, LCSW Quality Management Services Date: _____