Sacramento County
Department of Health Services
Division of Behavioral Health Services
CLINICAL TRAINEE EXTENSION REQUEST

Agency: _____ Date:_____

Contact Person: _____ Phone:_____

I attest that I, _____, continue to be a student/trainee at an accredited college or university participating in a field placement at this agency. I understand that I may provide services similar to an LPHA, except for the privilege of co-signing for other staff throughout this placement.

Expected graduation date_____
Date

I attest that I,_____, graduated from an accredited college or university participating in a field placement at this agency. I understand that I may provide services similar to an LPHA, except for the privilege of co-signing for other staff throughout this placement.

Name of College/University: _____

QM Approves Extention Start Date_____ and End Date_____
Date Date

Staff ID Number_____

Clinical Supervisor's Name_____ Discipline/License#_____

Taxonomy Number_____

Student Signature_____ Date_____

Clinical Supervisor Signature_____ Date_____

_____ Date_____
Approval: Rolanda Adams, LCSW, Quality Management Services