INTERNSHIP FORM

COASTAL HORIZONS CENTER

REGISTRATION FORM

School Affiliation

Internship Start and End Date

Area of Study ☐ COUNSELING ☐ SOCIAL WORK ☐ PSYCHOLOGY ☐ OTHER

Pursued Degree ☐ Associates ☐ Bachelors ☐ Masters ☐ PhD

PERSONAL INFORMATION

Name :

Preferred Pronouns :

Date Of Birth MM/DD/YY

Phone Number :

Area/Population of Interest :

Supervisor License :

type of supervisor license needed for practicu/internship: LCSWA, LCSW, LPA, LCMHCA, LCMHC, etc.

E-mail :

# of Weekly Internship hours :

Preferred day(s) of the week :

Preferred Site Location:

Other needed information:

Date of Request: MM/DD/YY

www.coastalhorizons.org

THANK YOU FOR YOUR INFORMATION

Email completed form to: intern@coastalhorizons.org