PsyD Program Application for Internship Course

Revised 2/16/2023

STUDENT INFORMATION			
Student Name:		Date of Application:	
Telephone:		Track: **OP** **Student ID:** _____	
Internship Start Date:		Internship Termination Date:_____	

APPLICATION INFORMATION

Submit form prior to the start of the quarter that you will be enrolled in internship. Select the Course, Term and enter the Year.

Enrollment Type: Internship   **Term**   **Year**

☐ **CY 980** - Pre-Doc Internship (3 Units each Quarter)
   Initial 3 consecutive quarter Internship enrollment (**check first quarter of the 3 consecutive quarter enrollment**). Selecting this course will cover three quarters of enrollment.

☐ Fall   _____

☐ Winter   _____

☐ **CY 980A** - Pre-Doc Internship Extension (0 Units each Quarter)
   4th quarter into internship or later. Students requesting an Extension will need to register for this status prior to the beginning of each quarter that is needed.

☐ Spring   _____

☐ Summer   _____

Student clinical files and financial accounts will be reviewed each quarter for eligibility. A quarterly fee will apply. Students may apply for financial aid for the initial 3 quarter enrollment period. Internship Extension enrollment is not eligible for financial aid and may affect your repayment schedule.

All training sites must first be approved in writing by the Director of Clinical Training.

Students must be enrolled in the Internship Course to accrue hours. Failure to complete this form before the quarter begins will impact your program timeline.

Eligibility Requirements for Internship Status:
☐ Successful completion of all coursework
☐ Passed the Comprehensive Exam
☐ Passed all Annual Assessments for
   Program Advancement
☐ Completed Practicum Training (before internship start date)
☐ Maintain Satisfactory Academic Progress
☐ Registration occurs within Program Time Limit date

Required Signatures:

_____ _____
Student   Date

_____ _____
Director of Clinical Training   Date

_____ _____
Registrar's Office   Date

_____ _____
Student Accounts Office   Date

_____
PTL date

_____
Start Date of Internship (Accrual of Hours)

OFFICE USE ONLY
Internship Start Date: _____
Date Form Received: _____

Students: Return completed form to clinicaltraining@pacifica.edu