PACIFICA GRADUATE INSTITUTE

Counseling MA Students Only

Clinical Practicum Registration Form

STUDENT INFORMATION			
Student Name:		Student ID Number:	
Telephone:		Track:	☐C ☐D ☐V ☐W

REGISTRATION INFORMATION

I, the undersigned, request enrollment in Clinical Practicum, CP 680 for the following term (select only one term/year per form). I have completed Clinical Practice I-VI. I am continuing as a trainee in an approved traineeship site and I am continuing to accrue traineeship hours.

Course ID	Credits	Term	Year
☐ CP 680	0.00 credits	Fall	____
☐ CP 680	0.00 credits	Winter	____
☐ CP 680	0.00 credits	Spring	____
☐ CP 680	0.00 credits	Summer	____

The Director of Clinical Training or Clinical Training Associate must first approve all training sites.

Instructions:
Complete, sign, and date this form.

Submit the completed and signed form to the Director of Clinical Training. Upon approval DCT will sign and forward to the Registrar's Office. A late registration fee will be assessed for approved forms received by the Registrar's Office less than 2 weeks before the start of the quarter.

Revised 10/2025

RO rcvd date:_____

Required Signatures: If emailing form, student must submit this form from their My.Pacifica.edu student email account.

_____ _____
Student Date
☐ I certify that my typed name is my authorized signature

_____ _____
Counseling Director of Clinical Training Date
☐ I certify that my typed name is my authorized signature

_____ _____
Registrar Date

PTL _____ Notify Traineeship Office_____