

Thank you for your interest in participating in our clinical counseling program. The Counseling and Human Resource Development (CHRD) program is an accredited counselor education satellite program offered by SDSU. Part of our master's level Practicum students training is to meet with client and conduct counseling sessions. The sessions are confidential, approximately 50 minutes long, and free. The sessions are held in our clinic rooms at the BHSU University Center. The sessions are taped for the purpose of evaluating counseling student progress. All DVDs are securely held within our clinic and are shredded at the end of the semester. Our students have completed the necessary prerequisites that are required before they can become a Practicum student counselor. All the students are supervised by CHRD faculty.

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Full Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

May we leave a voicemail? Yes \_\_\_ No \_\_\_ May we send an email? Yes \_\_\_ No \_\_\_

Please note: If initial contact is made via phone the phone number will appear as RESTRICTED or UNKNOWN on your phone.

If your professor is offering extra credit, please out the information below:

Extra Credit: Yes \_\_\_ No \_\_\_

- Course Prefix and Number \_\_\_\_\_ Section # \_\_\_\_\_ Instructor \_\_\_\_\_  
You must meet the number of required sessions and have your instructor's approval to receive the extra credit and by signing this form you are giving us permission to let your instructor know if you attended. Only attendance stats will be released.

SCHEDULE

	1-2	2-3	3-4	4-5	5-6	6-7	7-8	Other
Monday								
Tuesday								
Wednesday								
Thursday								

I, \_\_\_\_\_ (CLIENT NAME—please print), hereby give my permission for recording my counseling sessions at the BHSU University Center SDSU training counseling rooms. I understand that any recordings will solely for the purpose of supervision. I understand that if my counselor believes I present imminent danger to myself and/ or others, they are required by law to report this information. Other than these two limits, information from counseling will be kept strictly confidential. I also understand that any taped material will be erased after I terminate counseling.

Signed \_\_\_\_\_ (Client Signature) Date \_\_\_\_\_