

VERIFICATION OF PERSONAL COUNSELING

The signing of this form certifies that the student listed below has completed a minimum of six hours of individual counseling/therapy with the counselor/therapist listed below during the time period in which s/he has been registered in EPC 659A/B – Practicum at California State University, Northridge.

Name of Student (please print): _____

Name of Counselor/Therapist (please print): _____

Address _____

Phone(s) _____

Is counselor an advanced (second or later) year Master's student?
_____ Yes _____ No

If not a Master's student, please list professional title, type of license, and/or license number below:

Date counseling/therapy began: _____

Date counseling/therapy ended: _____

Total number of sessions in this time period: _____

Signature of Student

Signature of Counselor/Therapist