CANADIAN COUNSELLING AND PSYCHOTHERAPY ASSOCIATION
L'ASSOCIATION CANADIENNE DE COUNSELING ET DE PSYCHOTHÉRAPIE

Canadian Certified Counsellor (CCC)
PATHWAY ONE: Practicum Form

CCPA recommends that the co-signer submit the form directly to head office. Once the form has been received by CCPA, it cannot be modified or withdrawn. Please note that applicants can access the form with the consent of the co-signer or under the *Personal Information Protection and Electronic Documents Act*.This form is for applicants following PATHWAY ONE. Please submit one form per practicum placement.

INCOMPLETE FORMS WILL NOT BE PROCESSED

1. Applicant Information

Name:

First name: _____ Last name: _____

Other Legal Names: _____

Address:

Number and street: _____

City, Province, Postal code: _____

Email:

Email: _____

Telephone:

(home): _____ (cell): _____

(work): _____ (fax): _____

2. Practicum Course and Site Information

Course code and title: _____

Name of your practicum course professor: _____

Dates of Practicum (mm/yy) - (mm/yy): _____

Practicum Site Name: _____

Practicum Address: _____

This section refers to the primary clinical practicum supervisor who assumes primary responsibility for the student's work. Supervisors must have engaged in formal supervisory activities and meet the qualification requirements. All other supervisors must be listed in Section 4.

3. Primary Clinical Supervisor Information

Primary Clinical Supervisor Name: _____

Workplace and position title: _____

Email: _____ Telephone: _____

Graduate degree(s): _____ Specialization(s): _____

List your professional memberships / designations at the time you supervised the applicant (no acronyms):

_____

Did you have at least 4 years of post-graduate counselling experience at the time that you entered into a supervisory relationship with the student?

☐No ☐Yes

How many hours per week of supervision did you provide? *(numeric values only)*: _____

What types of supervision did you provide to the applicant *(check all that apply)*:

- ☐ Case consultation
- ☐ Class meetings
- ☐ Other *(please specify below)*:
- ☐ Direct observation
- ☐ Taped sessions
- ☐ Co-counselling / co-facilitating

_____

How did you provide supervision (check all that apply):

- ☐ In-person
- ☐ Telephone
- ☐ Other *(please specify below)*:
- ☐ Video Chat (Doxy, Zoom, Skype, etc.)
- ☐ Asynchronous means (email, text, other manner that isn't live)

_____

Is there any reason that you should not be considered an appropriate supervisor? (Please consider any dual relationship, role conflict, overlapping roles, personal relationship, conflict of interest, lack of knowledge of applicant's clinical work as a counsellor, outdated knowledge of applicant skills, etc).

☐No ☐Yes

Applicants must indicate all additional supervisors who provided formal supervision under Section 4 below, if applicable. Any additional supervisors who do not fit on this page should be identified to CCPA.

4.A. Additional Supervisors. Please list any and all formal supervisors, one per column.

Additional supervisor name:		
Graduate degree(s) and specialization(s):		
Professional memberships / designations at the time supervision occurred:		
Did the supervisor have at least 4 years of post-graduate counselling experience before they began supervising the applicant?	☐No ☐Yes	☐No ☐Yes
What percentage of the student's direct client counselling did they supervise? Ex, 10% of their clinical cases.		

4.B. Supervisor of Supervisor. Please list any individuals who supervised the supervision provided to the applicant.

Supervisor Name: _____

Workplace and position title: _____

Email: _____ Telephone: _____

Graduate degree(s): _____ Specialization(s): _____

List their professional memberships / designations when supervision occurred:

_____

Did they have at least 4 years of post-graduate counselling experience when supervision occurred?

☐No ☐Yes

Individual who received supervision: _____

5.A. Scope of Practice (please refer to the definition on CCPA's website)

Briefly describe the client population (age, milieu, typical presenting problem, etc.):

Describe the nature of the counselling services provided and the theoretical interventions you used:

5.B. Hours of Practicum

	Total number of hours:
Please indicate how many total hours the applicant spent providing direct client counselling, group counselling, and overall time spent at your practicum placement in the column to the right. The Registrar evaluating your file also needs to know, for each of these three types of services, the breakdown of the overall activities under each of the headings. Please also check off all activities in which you engaged at your practicum placement, and indicate in the column on the right approximately what percentage of time you spent engaging in each activity (ex. if your direct client counselling hours were entirely spent providing counselling session, please indicate 100% in the column on the right).	
Direct client counselling hours with individuals, couples and families Time spent working directly with clients providing therapy.	

*Intake: _____ *Psychoeducation: _____

Counselling Sessions: _____ Other Activities (please describe):

*Assessments: _____ _____

*Please note intake, assessment, psychoeducation and asynchronous cannot exceed 25% of total counselling hours.

Additional group counselling hours: Time spent working with groups. These hours are in addition to the hours listed above.	

Group Therapy: _____ Manualized group sessions: _____

Group Psychoeducation: _____

Total number of on-site hours: These are the total amount of hours you were on-site. They include your direct client hours above, group counselling hours above, and the amount of time you spent providing indirect services (note-taking, report-writing, supervision, research, consultation, preparation, etc.).	

How did the applicant provide the counselling services? Please check each type of service delivery methods used during the practicum placement, and beside each one specify approximately what percentage of your sessions were delivered using that platform. (ex. if you did all of your sessions in-person, check off in-person and indicate 100% beside it, but if you did half in-person and half video chat then you would check off those two types and indicate 50% beside each one).

- ☐ In-person
- ☐ Telephone
- ☐ Video Chat (Doxy, Zoom, Skype, etc.)
- ☐ Asynchronous means (email, text, other manner that isn't live)
- ☐ Other *(please specify below)*:

_____

6. COVID-19

Did COVID-19 negatively impact your ability to accrue direct client contact hours?

☐ No ☐ Yes (please specify): _____

7. Attestation *(REQUIRED)*

ATTESTATION (please check each box below to indicate your agreement):

☐ I attest to the accuracy of the information on this form. I am willing to answer additional questions concerning this evaluation if CCPA deems it necessary. I understand and consent to be contacted in follow-up to the provided information on this form.

☐ I confirm that as part of the practicum course requirements, a formal evaluation of the student's clinical competencies was completed by either the practicum course professor and /or clinical supervisor.

☐ I confirm that the student successfully passed the above stated evaluation.

Do you have any concerns about the applicant's fitness to practice, including but not limited to concerns about their ethical and competent practices? Any concerns that I am aware of will be disclosed to the Registrar. ☐ No ☐ Yes * If yes, please describe:

Are you aware of any concerns about the applicant's fitness to practice raised by other educators, clinical supervisors, administrative supervisors, clients, or other individuals involved in the applicant's practicum training? Any concerns that I am aware of will be disclosed to the Registrar.

☐ No ☐ Yes *If yes, please describe:

The applicant can complete the form and sign. This form must be verified with a signature from either an primary clinical supervisor or practicum professor who can attest to the accuracy of the information on this form.

*If a digital signature is provided by either the practicum professor or practicum supervisor, the form must be sent to CCPA directly from the individual who has provided the digital signature by email.

Applicant's Signature: _____ Date: _____

And either:

Practicum professor's name and title (printed): _____

Signature: _____ Date: _____

OR

Practicum supervisor's name and title (printed): _____

Signature: _____ Date: _____

Please send the form by Mail/Fax/Email to:
Canadian Counselling and Psychotherapy Association
202 - 245 Menten Place, Ottawa, ON, K2H 9E8
Fax: 613-237-9786; E-Mail: certification@ccpa-accp.ca

PRINT FORM