


Experience	Description of Practice:	CMBHC Internship	
	Location: City/State/Zip	Middlebury, VT 05753	
	Duration:	08 / 1 / 22 - 05 / 1 / 23	
	Status:	Full-Time	<u>Part-Time</u>
	Receive supervision or peer consultation?	<u>YES</u>	NO
	How often?	2x week	
Experience	Description of Practice:		
	Location: City/State/Zip		
	Duration:	___ / ___ / ___ - ___ / ___ / ___	
	Status:	Full-Time	Part-Time
	Receive supervision or peer consultation?	YES	NO
	How often?		
Experience	Description of Practice:		
	Location: City/State/Zip		
	Duration:	___ / ___ / ___ - ___ / ___ / ___	
	Status:	Full-Time	Part-Time
	Receive supervision or peer consultation?	YES	NO
	How often?		

Scope of Practice	Therapeutic Orientation:	
	Area of Specialization:	Individual, Group
	Treatment Methods:	IFS, Somatic Therapy

**My practice is also governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online at <http://vtprofessionals.org/>**

**Client's Disclosure Confirmation**

My signature acknowledges that I have been given the professional qualifications and experience of (Name, Name), a listing of that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.

Client's Signature	Date
	9/2/22
Practitioner's Signature	Date