Minnesota State University, Mankato
Alcohol and Drug Studies Program

Verification of Internship Experience

Student Name: ________________________________________  Internship Semester/Year: _________________

Address: __________________________________________________________________________________________
            (Street Address)    (City)   (State)   (Zip Code)

Tech ID: ______________________  Phone Number: ___________________  Cell Phone Number: _________________

Site Location Name: _______________________________________  Site Phone Number: ______________________

Site Supervisor: ____________________________________________________________________________________
            (First)    (Last)    (Credentials)

Site Address: ______________________________________________________________________________________
            (Street Address)    (City)      (State)   (Zip Code)

Date Internship Began: ___________________________  Date Internship Ended: _______________________

Total Clock Hours Completed: _______________________

Total Number of Hours Earned in each Core Function:

____ Screening          ____ Intake          ____ Orientation          ____ Assessment
____ Treatment planning  ____ Counseling     ____ Case Management      ____ Crisis Intervention
____ Client Education   ____ Referral       ____ Reports & Rec. Keeping  ____ Consultation
____ Other

Signatures of Approval:

_________________________________________________________________  ________________________________
Site Supervisor Signature  Date

_________________________________________________________________  ________________________________
ADS Coordinator Signature  Date

Please retain a copy of this form for your records.