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.

Revised 9/07