

## Annual Placement Availability Form

Date:					
Agency Name:					
Address:					
City:		State:		Zip:	
Contact Person:		Title:			
Credentials:					
Telephone #:		Fax #:			
Direct or Other Telephone #:					
E-Mail:	Agency Website:				
Disease indicate the total number of E	OCCOM Interner	aguantad.			
Please indicate the total number of BCSSW Interns requested:					
Clinical: First Year  Macro: First Year	Final Year Final Year				
Macro: First Year Summer Block Placement:		ry Ctart			
	Janua	ry Start:			
al Year					
Brief description of the student role and activities.					
Schedule: Please note if flexible hours are available or necessary for student assignments.					
Can the student reach your Agency by p	oublic transportati	on?	Yes	No	

No

Stipend amount: \$\_

Yes

Υes

Does the student need a car to provide Agency services?

Can your Agency provide a Stipend?

Agency Services: Please choose the practice area(s) which best describes the <u>focus</u> of your Agency. If more than one category applies, please rate them on a scale of 1 - 5.

Behavioral Health Administration Aging Behavioral Health Inpatient Behavioral Health Outpatient Childcare/ Early Invention Child Welfare/ Adoption/ Foster Care Colleges Death and Dying Community Planning & Development Developmental Disabilities Disabilities Employee Asst. Programs Family Services Forensic/ Criminal Justice Foundations/ Grants Government: City/ State