

**ST. STEPHEN'S COLLEGE
DEPARTMENT OF PSYCHOTHERAPY AND SPIRITUALITY
(MPS, MPS-AT, and PMATD Programs)**

PSYCHOTHERAPY HOURS VERIFICATION FORM

The therapist you work with must have a Master's/Doctoral degree in counselling therapy/ psychotherapy or a related field, and to maintain a professional certification with a related professional/regulatory body for the duration of the time you work together.

The SSC Clinical Director **must pre-approve the therapist prior to the beginning of psychotherapy** in order to ensure they have the appropriate training and credentials.

Note: Complete a separate form for each therapist that you work with.

PRE-APPROVAL OF THERAPIST	
Student's Name: _____	
Therapist's Full Name: _____	Credentials: _____
_____	_____
SSC Clinical Director Pre-approval	Date

VERIFICATION OF THERAPY HOURS

This is to certify that I have seen _____ for _____
(Student's Name) (Number of hours)

(check one) Individual Couples/Family Group

Psychotherapy sessions between _____ and _____
(Start Date) (End Date)

Therapist's Name (Print)

Credentials/Certification

Therapist Signature

Date

_____	_____
SSC Clinical Director Approval	Date