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

PSYCHOTHERAPY HOURS VERIFICATION FORM

If a student works with more than one therapist, a separate Psychotherapy Hours Verification Form needs to be submitted for psychotherapy hours completed with each therapist.

Therapist needs to have a Master's or Doctoral degree in counselling/psychotherapy and to maintain a professional certification such as Registered Psychologist, Marriage and Family Therapist, Registered Art Therapist, Canadian Certified Counsellor, Registered Clinical Counsellor, etc. Department Chair/ Co-Chair **must approve therapist prior to the beginning of psychotherapy**.

Individual Psychotherapy Hours

This is to certify that I have seen _____ for _____ individual
(Name of client) (Number)

psychotherapy sessions between _____ and _____
(Date) (Date)

Total Hours: _____

_____
Therapist Name (Print)

_____
Therapist Signature

_____
Professional Certification

_____
Date

Department Co-Chair Sign-off/Approval
Sign-off on Therapist Choice:

(signed)_____

Approval of completed Therapy Hours:

(signed)_____

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

PSYCHOTHERAPY HOURS VERIFICATION FORM
Verification of Other-than-Individual Psychotherapy Hours

If a student works with more than one therapist, a separate Psychotherapy Hours Verification Form needs to be submitted for psychotherapy hours completed with each therapist.

Therapist needs to have a Master's or Doctoral degree in counselling/psychotherapy and to maintain a professional certification such as Registered Psychologist, Marriage and Family Therapist, Registered Art Therapist, Canadian Certified Counsellor, Registered Clinical Counsellor, etc. Department Chair/ Co-Chair **must approve therapist prior to the beginning of psychotherapy**.

Other-than-Individual Psychotherapy Hours

This is to certify that I have seen _____ for _____ sessions
(Name of client) (Number)

in _____
(please specify Group/Couple/Family therapy)

between _____ and _____
(Date) (Date)

Total Hours: _____

_____
Therapist Name (Print)

_____
Therapist Signature

_____
Professional Certification

_____
Date

Department Co-Chair Sign-off/Approval
Sign-off on Therapist Choice:

(signed)_____

Approval of completed Therapy Hours:

(signed)_____