



american institute for stuttering

## Application for Clinical Internship

Name: \_\_\_\_\_ Student / Practicing Clinician  
(circle one)

Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Program year: \_\_\_\_\_  
(students only)

Address: \_\_\_\_\_

Email: \_\_\_\_\_

College/University: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

1. How did you hear of the Institute's clinical training program?

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2. Why are you pursuing a placement at the Institute?

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\_\_\_\_\_

3. Clinical Experience.

a. Approximately how many hours of direct speech/language/voice therapy have you completed with:

	Hours	Disorder
i. Preschool children (under 6 yrs)	_____	_____
ii. Younger school-age children (6-10 yrs)	_____	_____
iii. Older school-age children (10-17 yrs)	_____	_____
iv. Adults	_____	_____

b. Do you have experience in stuttering treatment? Yes \_\_\_\_ No \_\_\_\_.

If yes, please describe: number of hours \_\_\_\_\_; age groups \_\_\_\_\_

General approach taken: \_\_\_\_\_

\_\_\_\_\_

4. Please indicate whether you have experience with the following;

a. Fluency Shaping Techniques:

Easy breathing/full breath: \_\_\_\_\_ Easy onset/gentle starts: \_\_\_\_\_  
Soft contacts/Light touches: \_\_\_\_\_ Blending/continuous airflow: \_\_\_\_\_  
Prolongation: \_\_\_\_\_  
Gradual increase in length & complexity of utterance: \_\_\_\_\_

b. Attitudinal Techniques:

Avoidance reduction: \_\_\_\_\_ Self-talk strategies: \_\_\_\_\_  
Openness/acceptance of stuttering: \_\_\_\_\_ Desensitization: \_\_\_\_\_  
Meditation \_\_\_\_\_

5. Applicants for children's intensives: Please describe any experience you have in incorporating games into therapy exercises:

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6. Please list courses taken in stuttering. Attach course outlines and readings, including textbooks used.

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7. Please list psychology/counseling courses taken. Attach course outlines and readings, including textbooks used.

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8. **Practicing clinicians:** please list professional associations to which you belong and provide your membership or certification numbers.

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9. In which of the following ADULT / TEEN intensive clinics would you like to participate? All are for 12 years of age and older.

\_\_\_\_\_ JANUARY

\_\_\_\_\_ MARCH

\_\_\_\_\_ MAY

\_\_\_\_\_ JUNE

\_\_\_\_\_ JULY

\_\_\_\_\_ AUGUST

\_\_\_\_\_ OCTOBER

\_\_\_\_\_ DECEMBER

The exact dates for each year are posted on our website:  
<http://stutteringtreatment.org/treatmentschedule.htm>

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10. In what capacity would you like to complete this placement?

\_\_\_\_\_ Clinical internship/externship

\_\_\_\_\_ Non-credit

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

SEND TO: Catherine Montgomery, M.S., CCC-SLP, Director  
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New York, NY 10011  
Phone: (212) 633-6400 Fax: (212) 220-3922  
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