American Institute for Stuttering
27 West 20th Street, Suite 1203
New York, NY 10011
(212) 633-6400
www.stutteringtreatment.org

Application for Clinical Internship

Name: _____ Date: _____

Graduate Student / Licensed Clinician (CCC-SLP) *(circle one)*

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?

   _____

   _____

2. Why are you pursuing a placement at AIS?

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

3. Clinical Experience

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

		Hours	Disorder(s)
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 if you have experience with any of the following;

Voluntary Stuttering: _____	Easy onset/gentle starts: _____
Prolongations: _____	Pull-outs: _____
Cancellations:_____	Avoidance reduction: _____
Openness/acceptance of stuttering: _____	Desensitization: _____
Other:_____	

5. Please list courses taken in stuttering:

   _____

   _____

6. Please list psychology or counseling courses taken.:

   _____

   _____

7. Practicing clinicians - Please list professional associations to which you belong and provide your membership or certification numbers:

   _____

   _____

8. In which of the following adult or teen intensive programs would you like to participate? (The specific dates and times of our program are listed on our website: www.stutteringtreatment.org)

   a. _____ JANUARY

   b. _____ MAY

   c. _____ JUNE

   d. _____ JULY

   e. _____ AUGUST

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

   ___ Clinical internship/externship
   ___ Non-credit

_____ _____
Applicant's signature Date

MAIL, FAX or EMAIL TO:

American Institute for Stuttering
27 West 20th Street, Suite 1203
New York, NY 10011

fax: (212) 220-3922

email: admin@stutteringtreatment.org