THE GRADUATE SCHOOL AT UMBC

CERTIFICATION OF COMPLETION OF THE CLINICAL INTERNSHIP
Human Services Psychology, Ph.D. Students

Name: *(last, first, M.I.)*	
Student ID:	Graduation Term and Year: 20__

☐ This student has completed the required clinical internship as of

_____ .
Date of Completion

☐ An internship was not required for this student.

APPROVAL SIGNATURES Please **type and sign**		
Advisor:	Signature:	Date:
Director of Clinical Training:	Signature:	Date:

Revised by San Aung on 07/31/13