



THE NEW YORK INSTITUTE FOR PSYCHOTHERAPY TRAINING
In Infancy, Childhood and Adolescence
3701 Bedford Avenue
Brooklyn, New York 11229

CANDIDATE CLINIC PERFORMANCE EVALUATION FORM

Name of Candidate _____

Name of Clinic: _____

Address: _____

Name and phone number of Administrative Person: _____

Name of candidate's supervisor at clinic: _____

Date started at the clinic: _____

OVERALL COMPLIANCE WITH CLINIC REQUIREMENTS

	Satisfactory	Needs Improvement	Unsatisfactory
Clinical Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Record Keeping			
Content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timeliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administrative Relationships			
w/ other therapists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w/ admin staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w/ clerical staff:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w/ director(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance and Timeliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are parent contacts built into the treatment process? _____

Any other comments? *(if candidate needs improvement or is unsatisfactory please explain)*

Please note, anything that will help us evaluate the progress of this candidate is appreciated.

Please return this form to Eval Committee:

Mary Tirolo, Dean of Students 435 5th Street, Brooklyn NY 11215

Thank you, Dr. Phyllis Cohen, Executive co-Director, NYIPT