DEPARTMENT OF COUNSELING & DEVELOPMENT
INTERIM ASSESSMENT OF STUDENT
Required after 12 credits

DATE ________________________

NAME____
ID # ____
ADDRESS____
TELEPHONE______________________________
(Area Code)

FACULTY ADVISOR____

Credits completed at the end of this semester________________________________

It is necessary that the following courses be completed **PRIOR** to submitting this form:

School Counseling Specialization

EDC 602 Instructor ____
EDC 610 Instructor ____
EDC 615 Instructor ____
EDC 668 Instructor ____

Clinical Mental Health Counseling Specialization

EDC 601 Instructor ____
EDC 610 Instructor ____
EDC 614 Instructor ____
EDC 615 Instructor ____

If listed course work above has not been completed, please provide an explanation _______
____

I have met with my faculty advisor, ___________________________, for a review of my Plan of Study. The appointment was on __________________________.

____
Student Signature

____
Faculty Advisor Signature

For Department Use Only

APPROVAL GRANTED _____________________

APPROVAL DEFERRED ____________________

DATE ______________

Faculty Advisor: Please return this form to the Academic Counselor to be approved at the next department meeting.

u:lf/forms/interimassessment/February2015