



THE GRADUATE SCHOOL AT UMBC

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

Name: <i>(last, first, M.I.)</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:
Graduate Program Director:	Signature:	Date: