



Annual Placement Availability Form

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|------------------------------|-----------------|------|
| Date: | | |
| Agency Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Contact Person: | Title: | |
| Credentials: | | |
| Telephone #: | Fax #: | |
| Direct or Other Telephone #: | | |
| E-Mail: | Agency Website: | |

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| Please indicate the total number of BCSSW Interns requested: | |
| Clinical: | |
| Macro: | |
| Summer Block Placement | January Start: |

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| Brief description of the student role and activities. |
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| Schedule: |
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Agency Services: Please choose the practice area(s) which best describes the focus of your Agency. If more than one category applies, please rate them on a scale of 1 - 5.