Adapted/Innovative Placement Description Form

**Organisation:**

**Named Contact:**

**Contact Details**

***Email:***

***Website:***

***Telephone:***

***Address:***

**Lead Contact Tutor from DClinPsy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Organisation context & description** |  |
| **Organisation lead contact name and role** |  |
| **HCPC / professional registration number(s) if applicable.**  **Confirm DBS checked** |  |
| **Full time / part time**  ***(If part-time please note which days in work)*** |  |
| **Brief background of organisation contact person/s** |  |

|  |  |
| --- | --- |
| **Potential role of trainee**  **(e.g. service development / service needs assessment / therapeutic input)** |  |
| **Goals for the placement / evidence of outcome to be gathered** |  |
| **Facilities for trainees**  ***Are there any accessibility issues?***  ***Please detail these if you have circled yes*** | Yes/No |
| **Placement dates / schedule** |  |
| **Additional requirements to be considered**  **(e.g. external supervision / extra form of support from DClinPsy programme)** |  |

**Document Completed by (list all collaborators):**

**Date:**

**Document Review Date:**