

**PSYCHOSOCIAL ONCOLOGY PROGRAM**

**INTERNSHIP AND PRACTICUM PROGRAMS**

**APPLICATION FORM 2026-2027**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | Spoken | Written |
| English |  |  |
| French |  |  |
| Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  |

Languages:

**Program of Interest:** (Please Check) \_\_\_ Pre-Doctoral Internship (Half-time) \_\_\_\_ Practicum (2 -3 days a week)

**Area of Interest** (Please Check) \_\_\_\_ Psychosocial Oncology \_\_\_ Palliative Care \_\_\_\_ Both

**Current Education:**

University Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPA Accredited: Yes No OPQ Accredited: Yes No APA Accredited: Yes No

Indicate current year of PhD program: e.g. Qualifying year, Ph.D. 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected Date of Program Completion: \_\_\_\_\_\_\_\_\_ Degree to be Granted (Ph.D., Psy.D., Ed.D) \_\_\_\_\_\_\_\_

**Assessment Experience:**

List below all the psychological assessment instruments you have experience in: administration, scoring and interpretation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Domain | Name of Test | # Administered | # Scored | #  Interpreted/  Report |
| Cognitive, Intellectual | Wechsler Adult Intelligence Scales (WAIS-IV) |  |  |  |
| Personality | Minnesota Multiphasic Personality Inventory – Restructured Form (MMPI-3) |  |  |  |
|  | Personality Assessment Inventory (PAI) |  |  |  |
|  | Millon Clinical Multiaxial Inventory (MCMI-III) |  |  |  |
| Structured Clinical Interview | Structured Clinical Interview for DSM-IV-TR (SCID I) |  |  |  |
|  | Structured Clinical Interview for DSM-IV-TR Axis II (SCID II) |  |  |  |
| Depression/Anxiety | Beck Depression Inventory (BDI-II) |  |  |  |
|  | Beck Anxiety Inventory (BAI) |  |  |  |
|  | Patient Health Questionnaire (PHQ-9) |  |  |  |
| Please list other tests that you have experience with that do not appear above. | | | | |
|  |  |  |  |  |
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|  |  |  |  |  |

**Clinical Treatment Experience:**

Please indicate the number of clients you have seen in each column according to treatment modality, individual versus group, and length of treatment:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Modality | Number of Individual Clients | Number of Group Clients | Number of Short-Term Sessions (up to 12 sessions) | Number of Long-Term Sessions (more than 12 sessions) |
| Cognitive Behavioral Therapy |  |  |  |  |
| Psychodynamic Therapy |  |  |  |  |
| Acceptance and Commitment Therapy |  |  |  |  |
| Marital/Couple and/or family therapy |  |  |  |  |
| Dialectical-behavior Therapy |  |  |  |  |
| Other (please specify): | | | | |
|  |  |  |  |  |
|  |  |  |  |  |

Please indicate the number of clients you have seen for treatment in each column according to age and diagnosis:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Child | Adolescent | Adult | Geriatric |
| Anxiety Disorders |  |  |  |  |
| Cognitive Disorders |  |  |  |  |
| Eating Disorders |  |  |  |  |
| Mood Disorders |  |  |  |  |
| Personality Disorders |  |  |  |  |
| Sexual Disorders |  |  |  |  |
| Substance Use Disorders |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

List past practicum experiences:

|  |  |  |  |
| --- | --- | --- | --- |
| Location | Date Attended | Supervisor | Licensed Psychologist / Allied Mental Health |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you made recordings of clients/patients which were reviewed with your supervisor?

Audio Recording: Yes No Videotape/Digital: Yes No Live Observation: Yes No

Name, Address, Telephone Number and E-mail Address of Supervisors:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Address | Telephone | E-mail |
| Academic Supervisor |  |  |  |  |
| Director of Clinical Training |  |  |  |  |

Letters of Reference will be sent from the following (2):

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Address | Telephone | E-mail |
| 1 |  |  |  |
| 2 |  |  |  |

Psychosocial Oncology Supervisors Palliative Care Supervisor

Marc Hamel, PhD, Clinical Psychologist Marie-Solange Bernatchez, PhD, Clinical Psychologist

Lana M. Pratt, PhD, Clinical Psychologist

Pasqualina Di Dio, PhD, Clinical Psychologist

Samara Perez, PhD, Clinical Psychologist

Alice Paquet, Clinical Psychologist