

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

### **OBSERVATION/ASSISTING PERMISSION**

PTS participates with local colleges, universities and interested volunteers in allowing observation and assisting experiences within therapy sessions. This community service allows interested persons to gain information about the various disciplines and professional roles and responsibilities. Many of these persons are considering careers in these areas or related fields, and this service helps them make early decisions regarding their career path. These students/volunteers are counseled prior to their observation and/or therapy assisting activities regarding confidentiality of client information, and agree to abide by PTS policies on confidentiality as part of their observation and assisting experience.

*I hereby grant permission for observations and/or assisting of therapy to occur according to the above guidelines.*

Signed: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Witnesses by: \_\_\_\_\_

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

*I do not grant permission for observations and/or assisting of therapy to occur according to the above guidelines.*

Signed: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Witnesses by: \_\_\_\_\_

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