## CONSORTIUM PARTNERS/SIGN-OFF

## Master’s Programs

Consortium Name:

Program/Department Name (if applicable):

Location (City/State):

Identify the traditional substantive area:

Clinical  Counseling   School  Combined (list areas) Other practice area (list area):

Degree Offered:  MA MS Other:

Date of last CoA site visit (if applicable):

List all consortium affiliates, including addresses and the contact person for each site (add rows as needed):

|  |  |  |
| --- | --- | --- |
| **Consortium Site** | **Address** | **Contact Name/Title** |
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**Countersigners:** As *a master’s consortium program, we* ***REQUIRE*** *sign-off from the Institution Head of each individual consortium site. Please identify all of these individuals and provide contact information and a signature for each participating site. Signatures indicate that the self-study has been approved for submission and serve as an invitation to conduct a site visit to the program.*

|  |  |
| --- | --- |
| ***Institution/Agency Head (name):*** |  |
| **Signature (or that of designee\*):** |  |
| **Title:** |  |
| **Consortium Site:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |

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| --- | --- |
| ***Institution/Agency Head (name):*** |  |
| **Signature (or that of designee\*):** |  |
| **Title:** |  |
| **Consortium Site:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |

|  |  |
| --- | --- |
| ***Institution/Agency Head (name):*** |  |
| **Signature (or that of designee\*):** |  |
| **Title:** |  |
| **Consortium Site:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |

*(Add additional tables as needed)*

\*If signed by designee, provide the full name of that individual in addition to the name of the person for whom he/she signed.

**Optional Tables**

*The program is welcome to add any additional department/program contacts that should also provide sign-off. Please note that these individuals are an optional supplement to the required countersigners (i.e., Program Director, Department Contact).*

|  |  |
| --- | --- |
| ***Program Contact (name):*** |  |
| **Signature:** |  |
| **Title:** |  |
| **Consortium Site:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |

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| --- | --- |
| ***Department Contact (name):*** |  |
| **Signature:** |  |
| **Title:** |  |
| **Consortium Site:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |

*(Add additional tables as needed)*

**Please remember to upload a copy of the consortial agreement, signed by**

**ALL participating members.**