VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

(If you had more than one supervisor, please have **each** supervisor complete a separate form)

SUPERVISOR: PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS AT THE END OF THE FORM. **TYPE OR PRINT LEGIBLY.**

THE SUPERVISOR MUST COMPLY WITH THE FOLLOWING:

1. **Been licensed as an LPC, LPC-MHSP, LMFT, licensed psychologist, psychiatrist or LCSW for at least five (5) years; for MHSP status one may not be supervised by an LPC and one half of the hours MUST be supervised by an LPC/MHSP**
2. **Comply with Section F of the current code of ethics adopted by the American Counseling Association, except to the extent that it conflicts with the laws of the State of Tennessee or the Rules of the Board.**
3. **Complete twelve hours (12) training in supervision as defined by the Rule 0450-01-.10(1)(d) and submit verification of the hours with this form.**
4. **Provide supervision based on the definition of supervision as defined by Rule 0450-01-.10(2).**

Name Of Applicant: _____

Supervisor's Name: _____

Supervisor's Address _____

_____

Supervisor's Email address: _____ Telephone Number: _____

Approved Supervisor _____Yes _____No _____ Date of approval

Supervisor's License Number_____ State _____ Type Of License _____

If License is M.D. Or D.O., are you certified by The American Board of Psychiatry and Neurology? _____Yes _____No

Date of initial license: _____ Expiration date of license: _____

Is your license in good standing? _____ Have you ever had any disciplinary action taken against you or your license? ____ Yes ____No

If Yes, Please Explain: _____

_____

What was the job title of applicant during the time of your supervision:_____

Dates Of Supervision: From _____ To _____

What activities did/does your clinical supervision include:

- ❑ sign off on charts
- ❑ discuss individual cases briefly
- ❑ discuss individual cases in depth
- ❑ other (describe) _____
- ❑ treatment planning (for MHSP)
- ❑ DSM/diagnosis (for MHSP)
- ❑ member of treatment team

Location Where Clinical Experience Took Place: _____

_____

Description of Clinical Experience: _____

_____

_____

_____ Total Individual Supervision Hours
_____ Total Group Supervision Hours
_____ Total ALL Supervision Hours

_____ Total Clinical Hours (Individual, Group, Family)
_____ Total Other Hours (Paperwork, Training, Etc.)
_____ Total ALL Hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

Supervisor's Signature	License No.	Date

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES _____ AFFIX SEAL HERE

Send to:

Board for LPC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

This Form May Be Duplicated