NORTH CAROLINA BOARD of LICENSED CLINICAL MENTAL HEALTH COUNSELORS

Verification of Supervised Professional Practice

[To be completed by LCMHC Applicants and Supervisors]

Indicate to which Applicant this supervised professional practice form applies:

Name: _____

VERIFICATION OF SUPERVISED PROFESSIONAL PRACTICE INSTRUCTIONS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of supervised professional practice. Person verifying supervised professional practice must be a qualified clinical supervisor as defined in Rule .0209.
2. **ALL SECTIONS** must be completed or the verification of supervised professional practice will be returned.
3. The verification of supervised professional practice should be enclosed in a sealed envelope and signed across the flap. Mail the signed and sealed envelope to the **NCBLCMHC Board Office at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417**

I. GENERAL INFORMATION - *To be completed by person verifying supervised professional practice.*

Supervisor's Name (Last, First, Middle):

Title:

Name of Agency where Supervised Professional Practice occurred:

License Type and Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code):

Issue Date:

Business Phone:

Email Address:

II. SUPERVISED PROFESSIONAL PRACTICE-

Supervision Period: _____ (month/date/year) to _____ (month/date/year)

Modality of Supervision Used (check all that apply):

☐ Direct (Live) Observation/Supervision ☐ Co-therapy ☐ Audio Recording ☐ Video Recording

Supervised Professional Practice and Clinical Supervision:

Supervised Professional Practice (as defined in Rule .0208):
(no more than 40 per week)

Total # Hours **Indirect** Counseling: _____

Total # Hours **Direct** Counseling: _____

Individual Clinical Supervision (as defined in Rule .0210): Total # Hours: _____ *(no less than 1hr per 40 hrs worked)*

Group Clinical Supervision (as defined in Rule .0211): Total # Hours: _____ *(no less than 2hrs per 40 hrs worked)*

III. SUPERVISION SUMMARY - ***To be completed by supervisor.*** *Please provide a summary of the supervision activities completed with this supervisee as well as identify strengths and potential deficits of the supervisee. Attach additional pages as needed.*

Name of Applicant: *(Required)*_____

IV. PROFESSIONAL ASSESSMENT - *To be completed by supervisor.*

Please rate the applicant compared to other counselors you know on the characteristics listed below. Place a mark in the appropriate column for each characteristic using the following rating scale:

1 = Outstanding 2 = Above Average 3 = Average 4 = Below Average 5 = Not Qualified 6 = Cannot Evaluate

	1	2	3	4	5	6	Comments
Individual counseling skills							
Diagnostic skills							
Treatment planning implementation							
Appropriate referral making							
Appropriate record keeping							
Group counseling skills							
Personal integrity							
Consulting skills							
Insight into client's problems							
Ability to relate to co-workers							
Ability to be objective on the job							
Knowledge of assessment instruments							
Ethical conduct							
Concern for the welfare of clients							
Sense of responsibility							
Recognition of own limits							
Ability to keep material confidential							

V. REFERENCE - *To be completed by supervisor.*

I ☐ recommend ☐ do not recommend this applicant for unrestricted licensure as a NC Licensed Clinical Mental Health Counselor.

INITIAL (Required) _____

If you do not recommend this application for unrestricted licensure please indicate below your reasons why:

_____

_____

_____

VI. VERIFICATION - *To be completed by supervisor.*

I verify that the above information is accurate. The focus of the documented supervision sessions was based on raw data from clinical work which was made available to the supervisor through such means as live observation, co-therapy, audio and video recordings, and live supervision. The clinical supervision included a minimum of one hour of individual or 2 hours of group clinical supervision per 40 hours of counseling practice.

Supervisor's Signature: _____ **Date**: _____

After completing this form, please enclose it in a **sealed envelope**, **sign across the sealed flap**, and **return** to the NC Board of Licensed Clinical Mental Health Counselors.