

## Board of Professional Counseling Request for Supervised Practice

The Board of Professional Counseling (“the Board”) uses this form to consider whether to allow an applicant the ability to work for 120 days while a completed application with required documents is being processed.

**Applicants cannot begin work without Board approval.**

**An approval will not be granted if the following exists:**

1. No application on file with the Board;
2. No FBI criminal background result;
3. Positive criminal background result(s);
4. Termination from employment is reported; and/or
5. Prior disciplinary action by a licensure board in any state/jurisdiction is found.

If the supervised practice is approved, the allowance is only for work with the supervisor approved at the location identified below. **The allowance is a one-time issuance good for 120 days** from the date of approval. **If approved, applicants should keep the original form and provide a copy to the employer and supervisor for recordkeeping.**

**APPLICANT/SUPERVISEE:** Submit form to the Board. Results can be made the same day.

**Do not begin work unless approved by the Board. The Board may verify all information before issuance of form.**

**SUPERVISOR:** Complete this form to supervise an individual who has a completed pending application. As a supervisor you are fully responsible for the practice of an applicant for licensure.

**Do not begin supervision without a copy of the Board approved form. The Board may verify all information before issuance of form.**

**I. SUPERVISEE/APPLICANT (The applicant must have a complete application on file)**

1. Name of the Applicant: \_\_\_\_\_
2. Contact: \_\_\_\_\_

Daytime Phone

Email

**II. SUPERVISOR (The supervisor must be licensed in DC)**

1. Name of the Supervisor (print): \_\_\_\_\_
2. License Type:  LPC  Social Worker(LICSW)  Psychologist  Psychiatrist
3. DC License Number and Expiration Date: \_\_\_\_\_
4. Location of Supervision (print):  
 Agency Name: \_\_\_\_\_  
 Agency Address: \_\_\_\_\_
5. Duties of Supervisee/Applicant (select all that apply):  Counseling  Psychotherapy  
 Interviewing  Assessments  Evaluations  Treatment
6. Contact Information: \_\_\_\_\_

Daytime Phone

Email

I am the applicant/supervisee, I have submitted a complete application and all information on this form is true and accurate.

APPLICANT/SUPERVISEE SIGNATURE	DATE

I am the supervisor and all information on this form is true and accurate.

SUPERVISOR SIGNATURE	DATE

**FOR OFFICE USE ONLY**

Date supervision form submitted: \_\_\_\_\_  
 Application Type: \_\_\_\_\_  
 Date of Board review: \_\_\_\_\_ DC SEAL  
 Approved  Denied  Reason for Denial \_\_\_\_\_  
 Date supervision ends and the applicant can no longer work: \_\_\_\_\_  
**HRLA Staff: Print Name:** \_\_\_\_\_  
**HRLA Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please return this form in person to:  
 899 North Capitol Street, NE, 2nd Floor Washington, DC 20002