Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration
DC Board of Professional Counseling

Post-Graduate Supervised Experience Form

Applicants: Include this form with your application in a separate, sealed envelope with the supervisor's signature across the seal.

Only a supervisor can complete this form, when the applicant's supervision ends.

Name of the supervisee/applicant: _____

TO BE COMPLETED BY THE SUPERVISOR

After completing, return to applicant in a sealed envelope with your signature across the flap.

Name of Supervisor: _____

State of Licensure _____ Date License Issued: _____ Date of Expiration:_____
License Number:_____ License Type_____

Supervision Site
Name of Agency:_____

Address: _____ City_____ State____ Zip Code:_____

Dates of supervision: From_____ to _____= total number of weeks _____
(Month/Year) **(Month/Year)**

Full Time __ Part Time__

Number of hours the supervisee worked per week_____

Number of hours per week spent: _____ (Immediate supervision)

Number of hours per week spent: _____ (Group supervision- counts toward immediate supervision)

Number of hours per week spent: _____ (General supervision)

General supervision – supervision in which the supervisor is available to the person supervised, either in person or by a communications device. **(3300 hours required)**

Immediate supervision – supervision in which the supervisor is physically present with the person supervised and either discussing or observing the person's practice. **(200 hours required, at least 100 under a licensed professional counselor)**

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SUPERVISED EXPERIENCE FORM – CONTINUED

In your opinion, has the applicant demonstrated competency in the practice of counseling sufficient for licensure and the independent practice of counseling? YES NO

If you answered no please elaborate and use additional paper if needed

_____

_____

Supervision requirements must be in one or more supervisory experiences during work. Please place an "X" in the column that represents your evaluation of the applicant's competencies.

YES = The applicant has satisfactorily demonstrated competencies in this area
NO = Additional work is required to achieve competency **DNI =** Supervision did not include this area

COUNSELING AND PSYCHOTHERAPY TECHNIQUES	**YES**	**NO**	**DNI**
Conceptualizes and implements counseling practice from a working theoretical base and can articulate that theoretical foundation.			
Demonstrates a working knowledge and flexibility with different theories and techniques in working with a variety of:			
A. Clinical Problems (Specify)			
B. Populations (Specify)			
C. Unique aspects of clients – including culture, gender, sexual orientation, disability and developmental concerns (Specify)			
APPRAISAL, EVALUATION AND DIAGNOSTIC PROCEDURES	**YES**	NO	DNI
Demonstrates an ability to diagnose client's problems using appropriate methods (DSM-IV) and can justify the diagnosis based on case information.			
Uses appropriate instruments and clinical data to appraise client behavior.			
TREATMENT PLANNING & IMPLEMENTATION	YES	NO	DNI
Demonstrates an ability to develop and implement an appropriate treatment plan consistent with the diagnosis.			
CASE MANAGEMENT & RECORD KEEPING	YES	NO	DNI
Maintains appropriate clinical records and client data.			
Understands circumstances under which various records can be released.			
PROFESSIONAL IDENTITY & FUNCTION	YES	NO	DNI
Uses supervision and shows continuing development of counseling skills.			
Demonstrates knowledge of strengths and limitations of a LPC and the distinctive contributions of other mental health and health professionals.			
Makes appropriate referrals to other health providers and resources in the community.			
Handles appropriately, or knows how to handle, psychiatric emergencies.			
PROFESSIONAL ETHICS & STANDARDS OF PRACTICE	YES	NO	DNI
Understands and has discussed ethical issues concerning dual relationships.			
Knows the laws related to a counselor's duty in life-threatening situations, child & physical abuse, etc.			
Understands and has discussed the ethics of confidentiality and other legal and ethical issues.			

Signature of Supervisor: _____ Date: _____

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Supervision Calculation Form

Applicant's Name _____

LIST ONLY THE WORK EXPERIENCE AND SUPERVISION DOCUMENTED ON THE SUPERVISION VERIFICATION FORM(S)

(1) Name(s) of **PRACTICE/EMPLOYMENT SITE**(s).
(2) **DATES** of post graduate counseling experience under supervision of a licensed professional counselor.
(3) **WEEKS** of counseling experience under supervision.
(4) **HOURS** per week of post graduate counseling experience under supervision of a licensed professional counselor.
(5) **TOTAL** number of hours of post graduate counseling experience under supervision of a licensed professional counselor.
(6) Name of **SUPERVISOR(S)** providing supervision.
(7) Number of hours of face-to-face

THE NUMBER OF HOURS IN COLUMNS #5 AND #7 CANNOT BE THE SAME.

(1) Practice Employment Site	(2) Dates From	(2) Dates To	(3) Weeks		(4) Hours		(5) Total	(6) Name of Supervisor & Credential	(7) Hours of immediate face-to-face supervision
Example: DC Department of Health	Dec. 1, 2014	Feb 1, 2015	8	X	32	=	256	John Doe, LPC	60
				X		=			
				X		=			
				X		=			

TOTAL: _____ **TOTAL:** _____ **TOTAL:** _____
(Not less than *3500 hours) (Not less than *200 hours)

I hereby attest that the information given in this form is true and complete to the best of my knowledge.

_____ _____
Applicant Signature **Date**