Oregon Board of Licensed Professional Counselors & Therapists

INSTRUCTIONS
for
Post-Degree Supervised Work Experience

APPLICANT INSTRUCTIONS

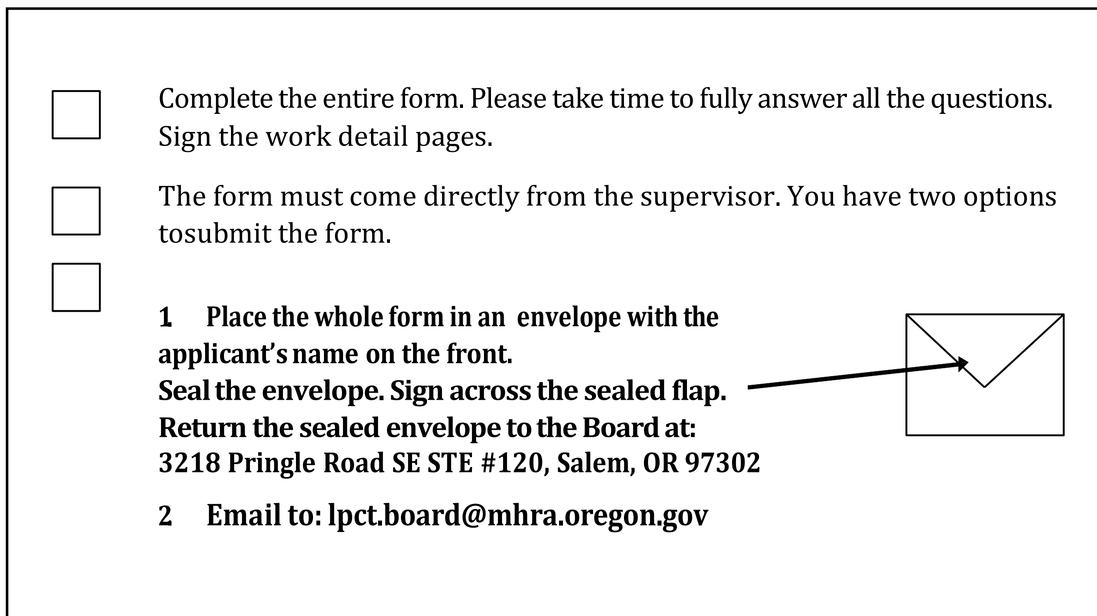
☐ Complete the Waiver on the first page for release of information by your direct clinical supervisor.

☐ The entire form must be completed and stapled together before submission.

☐ You may assist your supervisor in compiling the information, but the completed form must be returned to the board by your supervisor.

SUPERVISOR INSTRUCTIONS

You have been authorized to provide information documenting the applicant's experience as a counselor/therapist under your direct clinical supervision. This information will be part of a public record.



☐ Complete the entire form. Please take time to fully answer all the questions. Sign the work detail pages.

☐ The form must come directly from the supervisor. You have two options tosubmit the form.

☐

1 Place the whole form in an envelope with the applicant's name on the front.
Seal the envelope. Sign across the sealed flap.
Return the sealed envelope to the Board at:
3218 Pringle Road SE STE #120, Salem, OR 97302

2 Email to: lpct.board@mhra.oregon.gov

FORM #2: POST-GRADUATE SUPERVISED WORK EXPERIENCE

[ ] LPC [ ] LMFT

WAIVER

*I,*___________________________________[applicant *authorize*_____________________________[supervisor*] to provide the Oregon Board of Licensed Professional Counselors & Therapists with all information of any kind which the professional experience reference deems relevant to my qualifications as applicant for licensure. I hereby release and discharge the reference from all claims arising out of the provision of such information.*

____

Signature of Applicant *Date*

1. Location and type of clinical supervision: [ ] On-site supervision: [ ] Individual [ ] Group
[ ] Off-site supervision: [ ] Individual [ ] Group

2. Applicant's practice setting: [ ] agency [ ] private practice [ ] school [ ] institution

Agency/Business ____

Address ____

City, ST, Zip

3. Applicant's job title: ____

4. Applicant's counseling activities: ____

____

5. You reviewed: [ ] case notes [ ] charts [ ] records
[ ] audio or visual tapes [ ] assessments and treatment plans

6. Your direct supervision of client counseling hrs took place: From:________________To: __________________
Mo / Day / Yr Mo / Day / Yr

7. __________**Total number of client contact hours** of counseling for which you provided clinical supervision at this setting during this time -- as set forth in the attached detailed pages.

7a. Out of the total contact hours listed in #7, how many of these hours were related to working with couples and families? ________

8.__________**Total number of supervision hours** you provided.

Individual Supervision Hrs:__________ Length and Frequency of Meetings: ______________________________

Group Supervision Hrs: ________ Length and Frequency of Meetings: ______________________________

Group Size: ______

9. Did other people provide supervision for the same client contact hours listed in #6 above? [ ] **Yes** [ ]**No** If yes, please list other supervisors and indicate whether the supervision was individual or group supervision.

____

10. Did this applicant perform clinical work adequately? [ ] **Yes** [ ] **No** If no, explain on a separate sheet. Do you know of any reason why the applicant should not be licensed? [ ] **Yes** [ ] **No** If yes, please explain.

Supervisor Credentials

Fill in the following information about yourself at the time the supervision was taking place.

1. Graduate degree: ____________ In: ______________________ Date degree was issued: ______________
   [MA/ MS] [subject]
   From [institution]: ____________

   For LMFT applicants only: List graduate courses/ other training [but NOT experience] in marriage and family treatment specialties: ____
   ____
   ____

2. Mental health profession license, national supervisor credential, or national counselor / clinical supervisor certification held.

   ______________________________________ Date Issued: ______________________
   ______________________________________ Date Issued: ______________________

I attest the information I have provided the Board is true, and I take responsibility for the information I have provided.

____

Signature of Supervisor Date

Supervisor's Name, Address, and Telephone Number [please print legibly]:

____
____
____

Applicant ____

Setting: ____________________________________ Supervisor Signature: ________________________________
____________________________________ Date of Signature: ________________________________

List direct client counseling hours and formal supervision meetings. [Indicate if estimates are used rather than actual hours from recorded logs. The Board prefers actual hours, so please explain in writing how estimates were determined if used.]

Client Contact Period	Direct Client Contact Hours			Supervision Dates and Hours			
By Month / Year	Face to Face	By Phone	Total	Individual Face to Face	Individual By Phone	Group	Total Hours
EXAMPLE: May 2001	42	3	45	2		1.5	3.5
SUB TOTALS							

Photocopy additional blank detail forms as needed. Page______