FORM #7: ASSOCIATE SUPERVISED CLINICAL EXPERIENCE PLAN

- ❑ As part of your Initial Application, attach a **Professional Disclosure Statement** (PDS) for *each* employer/practice. Plans will not be approved until the PDS(s) are received.
- ❑ For Associate Plan Change Requests, adding or removing supervisors, attach a revised **Professional Disclosure Statement** for each employer/practice.

Applicant Name: _____

Registration Type: ☐ Professional Counselor Associate ☐ Marriage & Family Therapist Associate

1. SETTING – Location(s) applicant's employer/practice site*:*

LOCATION 1

Agency Name: _____

Location Address: _____

Mailing Address or PO Box: _____

City / State / Zip: _____

Telephone: _____

E-mail: _____

LOCATION 2

Agency Name: _____

Location Address: _____

Mailing Address or PO Box: _____

City / State / Zip: _____

Telephone: _____

E-mail: _____

2. SUPERVISION REQUIRED

Supervision is required every month. The minimum level of supervision depends on the number of hours accrued in a month. If the number of client contact hours in any given month is less than 46 hours, then the minimum supervision requirement is two (2) hours, with a minimum of one (1) hour of individual supervision. If the number of client contact hours in any given month is 46 hours or more, then the minimum supervision requirement is three (3) hours of supervision, with a minimum of one and a half ($1^{1/2}$) hours of individual supervision. You can exceed the minimum level of supervision per month. If you do not meet minimum monthly supervision requirements, then the client contact hours for the month will not be approved.

Provide a brief description of clients and counseling activities to be performed. Activities must include assessment, diagnosis and treatment of your clients:

_____

3. CLINICAL SUPERVISOR INFORMATION -- TO BE COMPLETED BY PROPOSED SUPERVISOR

Supervisor:

Name: _____

Business Address: _____

_____

_____

Phone: _____ E-mail: _____

Supervisor's Mental Health Graduate Degree(s):

School: _____ Degree: _____ Issued _____

School: _____ Degree: _____ Issued _____

How long have you known the applicant? years months Describe pre-existent relationship.

_____

Are you related to the applicant? ◯ Yes ◯ No

Have you ever been disciplined by any regulatory board? ◯ Yes ◯ No

If applicant is seeking registration as a marriage & family therapist associate, please list graduate-level training in systemic theory and approach to couples and families issues:

_____

Supervisor's Clinical Experience in counseling or marriage & family therapy:

Number of years licensed in Oregon: _____

Approved Supervisor/Candidate on the OBLPCT Supervisor Registry (LPC/LMFT only): ◯ Yes ◯ No

Supervisor's State License / National Credential:

License Title		Issued by [state or national org.]
License No		
Original issue date		Expiration date

License Title		Issued by [state or national org.]
License No		
Original issue date		Expiration date

4. SUPERVISION TRAINING.

Completed 30 clock hours of **post-masters training** in supervision theory and practice through workshops, or academic coursework, or completed the necessary requirements to be an AAMFT approved supervisor, NBCC approved clinical supervisor, or an APCA diplomate. List coursework, workshops, seminars, or national accreditation:

Title of class / workshop / seminars National Accreditation	Sponsor of program	Date taken	No. of clock hrs

SUPERVISOR AGREES TO:

Supervision:

- Ensure compliance with Board's current Oregon Administrative Rules.
- Provide ongoing, clinical supervision in a professional setting.
- Ensure that supervision of the supervisee is conducted face-to-face or through live, synchronous confidential electronic communication.
- Discuss and review case notes, charts, records, and available audio or video for all clients with the registered associate.
- Review and closely supervise the registered associate and all problem cases, providing special attention to assessments, diagnosis, treatment planning, ongoing case management, emergency intervention, record keeping, and termination.
- Focus on the appropriateness of the treatment plans and monitor the appropriateness of clients served based on the registered associate's therapeutic skill. Direct the registered associate to refer clients who fall beyond their level of competence.
- Maintain confidentiality of all client and supervisory materials.
- Review the Oregon licensing laws (ORS 675.705 – 675.835), administrative rules (OAR 833), and Code of Ethics (OAR 833, Division 100) with registered associate.
- Ensure the registered associate is using an appropriate title and including the supervisor's name and designation as "supervisor."
- Promptly notify the Board there are ethical concerns regarding the registered associate.

Reporting:

- Establish and maintain a record-keeping system to track the direct client contact and supervision hours. Supervisor will be prepared to provide supporting documentation verifying the accuracy of information reported, if requested by Board.
- Ensure that the Six-month Registered Associate Supervisor Evaluation and Reported Hours are submitted to the Board within one-month of the end of the reporting period.
- Notify the Board of any changes to supervisor's business address and phone number or change in credential status.
- ***Notify the Board of any interruption or proposed termination of the plan.***

REGISTERED ASSOCIATE AGREES TO:

- Abide by the Code of Ethics for Counselors and Therapists as specified in OAR 833, Division 100 and Oregon law and rules for LPCs and LMFTs.
- Distribute Professional Disclosure Statements to clients at the onset of therapeutic services.
- Establish and maintain a record keeping system to track the direct client contact and supervision hours.
- Submit requests to modify this plan to the Board and receive approval prior to implementing changes.
- Ensure supervisor has authority to review all records, determine appropriateness of records, direct referrals of inappropriate clients, determine caseload, and report to Board.

TERMINATION OF ASSOCIATE REGISTRATION

Associate registration may be terminated (and licensure application closed) for the following reasons:

- Failure to obtain prior approval of the Board for changes in plan terms: place of practice[s]; supervisor[s], including license/certification status; and level of supervision.
- Failure to file a replacement plan within 90 days of the termination of supervisor.
- Failure to file a replacement plan within 90 days of the termination of a place of practice/ employment.
- Failure to submit a Registered Associate Six-Month Supervisor Evaluation & Hours Report.
- Failure to notify or file a replacement plan after placing internship on a 90-day hold.
- Failure to renew registration.
- Voluntary resignation or withdrawal of application.
- Exceeding five years from initial date of registration.

CERTIFICATION / SIGNATURES

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to follow the provisions set forth in this plan. I understand my responsibilities. I understand that knowingly making a false statement in connection with this proposed plan may result in disciplinary action. I have been given a copy of this Associate Supervised Work Plan, Pages 1 - 4.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Clinical Supervisor Date

Associate Instructions for Submitting Completed Form

- ❑ Provide copies of this form for all signatories.
- ❑ Submit this form, via the Board's Portal, with original signatures and a Professional Disclosure Statement for each work location.
- ❑ Receive notification from the Board that the Plan has been approved *before* beginning practice.
- ❑ Supervisors do not have the option to upload the form in their portal.