BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS
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Oregon.gov/OBLPCT

Registered Associate Supervisor Evaluation & Hours Report

Registered Associate: _____ **Registration #:** _____

Initial Registration Date: _____ **Supervisor:** _____

Reporting Period From (MM/DD/YY): _____ through _____

Sample Report (Only Showing 6-Month Period)								
Months	Dates		Direct Hours		Supervision Hours			**Total**
	Start	End	A	B**	C	D	E	C, D + E
1	7/18/23*	7/31/23	42	12	2	1	2.5	5.5
2	8/1/23	8/31/23	10	10	2	1	2.5	5.5
3	9/01/23	9/30/23	10	10	2	1	2.5	5.5
4	10/01/23	10/31/23	10	10	2	1	2.5	5.5
5	11/01/23	11/30/23	10	10	2	1	2.5	5.5
6	12/01/23	12/31/23	10	10	2	1	2.5	5.5
TOTALS			92	62	12	6	15	33

*The first reporting period begins the day that an initial registration is approved. Reports are required every 12-months thereafter at registration renewal and a final report is due at the conclusion of supervision.

REPORTED HOURS

Report								
Month	**Date Range**		**Direct Hours**		**Supervision Hours**			**Total**
	Start MM/DD/YY	**End** MM/DD/YY	(A) Total Direct Client Hours, including telephone & electronic	(B)** *LMFT Applicants Couples & Family* ***(B is included in A)***	(C) Individual In-Person Supervision	(D) Individual Electronic Supervision	(E) Group Supervision	(C, D + E) **SUPERVISION TOTALS**
1								0
2								0
3								0
4								0
5								0
6								0
7								0
8								0
9								0
10								0
11								0
12								0
TOTALS			0	0	0	0	0	0

** Number of Reportable Couples and Family hours (LMFT applicants only)

SUPERVISOR EVALUATION

1. Has the Registrant passed the National Competency Examination?
   Yes ◯ *No* ◯ (Please visit the Exam page for information about important deadlines).
2. Has the Registrant taken the Oregon Laws & Rules exam?
   Yes ◯ *No* ◯ (Please review original email sent when application was approved for exam link).
3. What theory base or therapy underlies the Registrant's practice?

   _____
4. Does the Registrant demonstrate an understanding of assessment, diagnosis, and treatment planning?
   Yes ◯ *No* ◯
   If not, please describe how you are addressing the lack of experience:

5. Is the Registrant gaining experience in the diagnosis of mental disorders?
   Yes ◯ *No* ◯
   If not, please describe how you are addressing the lack of experience:

6. Is the Registrant distributing a Professional Disclosure Statement at onset of counseling (if required)?
   Yes ◯ *No* ◯ *N/A* ◯
7. Does the Registrant understand Oregon's laws and rules regulating LPCs and LMFTs?
   Yes ◯ *No* ◯
8. Do you routinely discuss the above with emphasis on the OAR Code of Ethics?
   Yes ◯ *No* ◯
9. Please evaluate the Registrant's strengths and weaknesses:

10. Please describe the Registrant's goals for professional growth in the next six months:

11. Do you have any concerns regarding this Associate being licensed?
    Yes ◯ *No* ◯
12. Is the Associate competent and practicing at an acceptable standard within the profession as a whole?
    Yes ◯ *No* ◯

Supervisor(s) Signature: _____ Date: _____

_____ Date: _____

Associate Signature: _____ Date: _____

Registered Associates must submit this fully completed and signed report in the Licensee Portal.