COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: coun@dhp.virginia.gov
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

LPC APPLICATION INSTRUCTIONS
ADD/CHANGE Registration of Supervision for a Resident in Counseling

This includes adding or changing supervisor and adding or changing a worksite.

Completed Application: The application must be signed by the resident and supervisor. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

Application Fee: A fee of **$30.00** is required for an application for adding or changing a supervisor to be processed. *There is no fee for adding or changing a worksite.* All fees paid by check or money order must be made payable to the "Treasurer of Virginia". This fee is non-refundable. The application is valid for one year from date of receipt.

The below supplemental documentation must accompany your application and fee in one packet:

- ☐ **Supervisor must be a LPC or LMFT with Evidence of Supervision Training**: If your supervisor is not listed on the Supervisor Registry, you must submit evidence that your supervisor received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106.

- ☐ **Name Change**: If applicable, documentation must be provided if your name has legally changed through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

Please note:

Supervised work experience occurring in Virginia, in any setting, must be registered and approved by the Board prior to beginning that supervision. An applicant may not count hours towards licensure unless that supervised experience has been registered with the Board. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of board-approved supervision.

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Add or Change of Registration of Supervision for a Resident in Counseling

Military/Military Spouse:

Are you active duty military personnel? □ **Yes** □ **No**

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? □ **Yes** □ **No**

- ☐ Add a Supervisor ($30.00 fee)
- ☐ Change a Supervisor ($30.00 fee)
- ☐ Add/Change a Worksite (no fee)

LPC
Licensed Professional Counselor

Complete All Sections

Application Fee of $30.00 for add/changing supervisor. Non-Refundable

No fee is required for add/change of worksite.

Application forms lacking a Social Security or VA DMV number will not be processed.

Mail all required documentation and fee to:

Board of Counseling
9960 Mayland Dr., Suite 300,
Henrico,
Virginia 23233

All signatures must be original.

Legal Name (First, Middle, Last)

Other Names Used on Official Documents (i.e. transcripts)

Sex (Circle) Male Female

Public Address (Street/Box Number, City, State, Zip)

Mailing Address (Street/Box Number, City, State, Zip)

Home Phone Cell Phone

Business Phone with extension

Email

Social Security Number (or VA DMV #) Date of Birth

List all currently approved supervisors. Check "yes" if you are remaining under supervision with a previously approved supervisor. Check "no" if supervision has terminated.

Supervisor Name:	**Worksite:**	
		Yes No
		Yes No
		Yes No
		Yes No

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Add or Change Registration of Supervision for a Resident in Counseling – Page 2

Ethics Attestation: Please answer the five questions below. **If you answer yes to any question, include a detailed explanation or supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction.**

1. Have you ever been denied the privilege of taking an occupational license or certification examination? If yes, state what type of occupational examination and where: _____ □ **Yes** □ **No**

2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper □ **Yes** □ **No**

3. Have you ever been convicted of a violation or pled nolo contendere to any federal, state or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence). If yes, explain in detail on a separate sheet of paper and provide court documents. □ **Yes** □ **No**

4. In the last twelve (12) months, have you been unable to practice counseling by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental of physical condition? If yes, please provide an explanation on a separate sheet of paper. □ **Yes** □ **No**

5. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper. □ **Yes** □ **No**

6. Are you the respondent in any pending or unresolved board action in another jurisdiction or in malpractice claim? □ **Yes** □ **No**

Per the Regulations, only a qualified LPC or LMFT can supervise a resident in counseling

SUPERVISOR'S INFORMATION:		
Supervisor's Name: (Last, First)	License Number:	License Type:
Business Name and Address of Supervisor's worksite:		
Email Address:	Business Phone Number:	

Supervisors: If you are listed on the Supervisor registry on the Board's website, you are not required to complete this section. Otherwise, please provide the information requested below, along with certificates of completion or transcript.

Date	Organization that provided training	Title of the seminar/conference/workshop	Credit hours

Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide counseling services. (one worksite)

Worksite Name:
Worksite Mailing Address (Street and/or Box Number, City, State, Zip

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Add or Change Registration of Supervision for a Resident in Counseling – Page 3

Please indicate if the supervised experience during the residency will be in the role of a professional counselor working with various populations, clinical problems and theoretical approaches in the following areas as required by 18VAC115-20-52.

Does this worksite and position incorporate all of the below requirements? If not, explain on separate page. • Assessment and diagnosis using psychotherapy techniques • Appraisal, evaluation and diagnostic procedures • Treatment planning and implementation • Case management and recordkeeping • Professional counselor identity and function • Professional ethics and stands of practice	Yes No If no, explain on separate page
Will the supervisor be on-site in the same facility where the resident is providing services?	Yes No

Resident's Initial	Supervisor's Initial	Statement of Assurance
		I have read, understand and intend to comply with the regulations that govern the Virginia Board of counseling licensees and applicants.
		I understand that the Supervisor is prohibited from providing supervision to any individual whose relationship with the Supervisor would compromise objectivity.
		I understand that the Supervisor assumes full responsibility for the clinical activities of the Resident for the duration of the residency. The Supervisor is responsible for ensuring that the Resident does not practice outside of the scope of his/her education.
		I understand that the Supervisor shall complete evaluation forms to be given to the Resident at the end of each three-month period.
		I understand that the Supervisor shall report the total hours of residency by completing the verification of supervision form at the end of the residency.
		I understand that the Supervisor must immediately report to the Board any unethical practice performed by the Resident, in accordance with regulation 18VAC115-20-130.
		I understand that the Supervisor must ensure that all clients of the Resident are informed of the Resident's status and the Supervisor's contact information.
		I understand that the residency must be completed in no less than 21 months and no more than four years.
		I understand that the Resident may only use the title "Resident in Counseling" and shall not present himself/herself in a way that may appear to be independent practice.
		I understand that the Supervisor will ensure that the Resident does not bill directly for services and that all payments, both cash and insurance, are paid to the Supervisor, or the Resident's employer.
		I understand that any violations of the regulations by the Supervisor or the supervisee, including but not limited to allowing unlicensed practice, misrepresenting the Resident's status to clients, allowing the Resident to bill directly, may result in disciplinary action before the Board of Counseling.

I attest that the information contained within the application is true and accurate to the best of my knowledge and belief.

Resident Signature:	Date:
Supervisor Signature:	Date:

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QUARTERLY EVALUATION FOR LPC LICENSURE

Section 115-20-52-D-3 of the Virginia regulations requires that the applicant's supervisor provide quarterly evaluations to the resident. This form must be signed and dated by the supervisor. **This form is to be completed by the supervisor each quarter and provided to the resident to be held in their possession until they are ready to submit their licensure application.**

Name of Applicant (Last, First, Middle)	Applicant's Email Address

SUPERVISOR'S EVALUATION:

Supervisor's Name (Last, First)	License Number:	License Type:
Business Name and Address of Residency Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)		
Dates of supervision: From (mm/dd/yy): _____	To (mm/dd/yy): _____	

All Columns Must Be Completed	Hours per week	Total hours	Hours are duplicated on another supervisor's quarterly form
Total hours of supervised residency (face-to-face client contact hour + ancillary hours)			Yes No
How many Face-to-face Client Contact hours did the resident provide?			Yes No
How many Individual Supervision hours did the resident receive?			
How many Group Supervision hours did the resident receive?			
If applicable, Total number of face-to-face client contact with Couples and Families or both.			Yes No
If applicable, Total number of face-to-face client contact hours clinical substance abuse treatment services.			Yes No

These areas are outlined in Section 18 VAC 115-20-52 of the Regulations. The resident must have supervised residency in the **role of a professional counselor working with various populations, clinical problems, and theoretical approaches** in the below areas.

Did the applicant provide **assessment and diagnosis using psychotherapy techniques** while under your direct supervision?	Yes No
Did the applicant provide **appraisal, evaluation and diagnostic procedures** while under your direct supervision?	Yes No
Did the applicant provide **treatment planning and implementation** while under your direct supervision?	Yes No
Did the applicant provide **case management and recordkeeping** while under your direct supervision?	Yes No
Did the applicant demonstrate minimum competencies of **professional counselor identity and function** while under your direct supervision?	Yes No
Did the applicant demonstrate minimum competencies **professional ethics and standards of practice** while under your direct supervision?	Yes No
Do you have any concerns about the competency of the resident? If yes, explain on separate page.	Yes No
Supervisor Sign Supervisor Signature:_____	Date:_____

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REQUEST FOR TERMINATION OF SUPERVISION

This form should be used to notify the Virginia Board of Counseling of the termination of a board-approved supervisory contract between a supervisor and resident-in-counseling. At the conclusion of the supervised residency, the supervisor shall provide the resident with a completed Verification of Clinical Supervision form to be held in their possession until they are ready to submit their licensure application.

Resident-in-Counseling Information:

Resident's Name (Last, First, Middle)	Resident's Telephone Number
Resident's Email Address	

Supervisor's Information:

Supervisor's Name (Last, First)	Supervisor's Telephone Number
Supervisor's Email Address	Supervisor's License Number:

Supervised Residency Information:

Name of Supervision Work Site:
Address of Supervision Work Site (Street, City, State, Zip):
Date of Termination:

Please email, fax or mail this completed form to:

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