COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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QUARTERLY EVALUATION FOR LPC LICENSURE

Section 115-20-52-D-3 of the Virginia LPC 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 LPC 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's Signature:_____ Date:_____