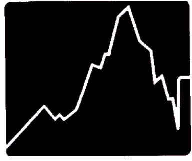

COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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

VERIFICATION OF CLINICAL SUPERVISION FOR LPC LICENSURE

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY

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

SUPERVISOR'S EVALUATION:

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

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): ____________________ Total Months:__________

Question		
Did the resident receive a minimum of one (1) hour and a maximum of four (4) hours of in-person supervision per 40 hours of work experience while under your **direct supervision**?	Yes	No If no, explain on separate page
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
Did the applicant complete a minimum of 3,400 hours of supervised residency in the role of a professional counselor working with various populations, clinical problems and theoretical approaches under your **direct supervision**? If not, how many? __________	Yes	No
Did the resident complete at least 2,000 hours of face-to face client contact in providing clinical counseling services while under your **direct supervision**? If not how many? ___________	Yes	No
Did the applicant demonstrate minimum competencies of **assessment and diagnosis using psychotherapy techniques** while under your direct supervision?	Yes	No
Did the applicant demonstrate minimum competencies of **appraisal, evaluation and diagnostic procedures** while under your direct supervision?	Yes	No
Did the applicant demonstrate minimum competencies of **treatment planning and implementation** while under your direct supervision?	Yes	No
Did the applicant demonstrate minimum competencies of **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
In your opinion has the applicant demonstrated competency sufficient for licensing and the independent practice in clinical counseling services? If not, explain on separate page.	Yes	No

I declare that, to the best of my knowledge, the foregoing is true and correct. This evaluation has been discussed with the resident and a copy has been provided to the resident.

Supervisor Signature:____ Date:______________

Revision date: 2/2017