Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

VERIFICATION OF SUPERVISION FOR LSATP LICENSURE – Page 1

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(S) OF RESIDENCY WORK SITE(S) WHERE CLINICAL HOURS WERE OBTAINED _____ _____ _____	**ADDRESS** OF RESIDENCY WORK SITE WHERE CLINICAL HOURS WERE OBTAINED _____ _____ _____		
Dates of supervision: From (mm/dd/yy): _____ To (mm/dd/yy): _____ Total Months:_____			

Under your **direct supervision**, 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 and was the supervision concurrent with the residency?	☐ Yes ☐ No If no, explain on separate page	
Was a signed supervisory contract in effect before counting hours toward licensure?	☐ Yes ☐ No	
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
How many total supervised residency hours, in a supervised residency in substance abuse treatment with various populations, clinical problems and theoretical approaches did the resident provide under your **direct supervision**? (Do not include hours obtained under another supervisor) (Total residency = ancillary + face-to-face client contact)	_____ hours	
How many total hours of **face-to face client contact**, in providing clinical substance abuse treatment services, did the resident provide while under your **direct supervision**? (Do not include hours obtained under another supervisor)	_____ hours	
Did the applicant demonstrate minimum competencies of **clinical evaluation** while under your direct supervision?	☐ Yes ☐ No	
Did the applicant demonstrate minimum competencies of **treatment planning, documentation and implementation** while under your direct supervision?	☐ Yes ☐ No	
Did the applicant demonstrate minimum competencies of **referral and service coordination** while under your direct supervision?	☐ Yes ☐ No	
Did the applicant demonstrate minimum competencies of **individual and group counseling and case management** while under your direct supervision?	☐ Yes ☐ No	
Did the applicant demonstrate minimum competencies of **client family and community education** while under your direct supervision?	☐ Yes ☐ No	
Did the applicant demonstrate minimum competencies **professional and ethical responsibility** while under your direct supervision?	☐ Yes ☐ No	

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VERIFICATION OF SUPERVISION FOR LSATP LICENSURE – Page 2

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

In your opinion has the applicant demonstrated a minimum competency to safely practice and is sufficient for licensing and the independent practice in clinical substance abuse service?	☐ Yes ☐ No
If you marked "no", does the lack of competency warrant a complaint to be investigated? (If you answered yes, the Board will open an investigation and you will be contacted to provide additional evidence of your concerns.)	☐ Yes ☐ No
Comments:	

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:_____

AFFIDAVIT: The following statement must be executed by a Notary Public.

State of _____, County of _____

Name _____, being duly sworn, says that he/she is the person who supervised the foregoing applicant for licensure; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary: _____.

My commission expires on _____.

My Commission # (if applicable): _____. SEAL