FORM #7: INTERN SUPERVISED WORK PLAN

- ❑ As part of your Initial Application Submittal, attach a **Professional Disclosure Statement** (PDS) for *each* employer/practice. Plans will not be approved until the PDS(s) is received.
- ❑ For Intern Plan Change Requests, adding or removing supervisors, attach a revised **Professional Disclosure Statement** for each employer/practice.

Applicant Name:____ [ ] LPC intern [ ] LMFT intern

PLAN TERMS

1. PROPOSED EFFECTIVE DATE OF PLAN: ______/______/______

Registered Interns have five (5) years to complete their supervised work experience from "official" date of registration with the option of reapplying for an additional five (5) years.

SETTING – Location**(s)** applicant's employer/practice site*:*

LOCATION A

Agency Name: ____

Location Address: ____

Mailing Address or PO Box: ____

City / State / Zip: ____

Telephone: ____

E-mail: ____

Name of Administrative Supervisor
or Employer Representative: ____
Address, if different from above: ____

____

Telephone: [ ] _______________ ____

LOCATION B

Agency Name: ____

Location Address: ____

Mailing Address or PO Box: ____

City / State / Zip: ____

Telephone: ____

E-mail: ____

Name of Administrative Supervisor
or Employer Representative: ____
Address, if different from above: ____

____

Telephone: [ ] _______________ ____

3. SUPERVISION REQUIRED: Within the six-month reporting period, direct contact hours may vary from 45 or less hours in one month to 46 or more hours the next month. **You must receive the minimum level of supervision per month specified below**. You can exceed the minimum level of supervision per month. If you do not meet minimum monthly supervision requirements hours will not be approved for the month.

☐ **45 or less client contact hours per month = no less than 2 hours supervision per month**.

☐ **46 or more client contact hours per month = no less than 3 hours supervision per month.**

A. Number of Direct Client Contact Hours anticipated per month: ______________

B. Intern's Meetings with Supervisor per month: Individual: Group:
i.e. How often do you meet with your supervisor(s) per month and is it individual or group supervision.

C. Brief description of clients and counseling activities to be performed:

____

____

____

____

4. SUPERVISION:

A. Name of Clinical Supervisor: ____

B. Where Supervision will occur: [ ] Supervisor's Office [ ] Applicant's Office [ ] Other

C. Is supervisor paid for supervision? [ ] Yes [ ] No
Amount: $_______ [ ] hr
Paid by: [ ] Applicant / Supervisee [ ] Agency [ ] Other:

SUPERVISOR:
How long have you known the applicant? ___ yrs ___ mos. Describe pre-existent relationship.

____

____

To your knowledge, has the applicant ever been convicted of substance abuse, or any offense involving controlled substances or alcohol, or of a felony in state or federal court? [ ] yes [ ] no If yes, please describe:

____

____

____

____

List any Oregon LPCs, or LMFTs, or applicants for LPC / LMFT you have supervised in the past or are currently supervising for the purposes of licensure:

____

____

____

____

5. CLINICAL SUPERVISOR INFORMATION -- TO BE COMPLETED BY PROPOSED SUPERVISOR.

Name: ____________________
Business Address: ____________________
____
____

Phone: ____________________ **E-mail:** ____________________

A. MENTAL HEALTH GRADUATE DEGREE[s]:

School: ____________ Degree: ____________ Issued: ________

School: ____________ Degree: ____________ Issued: ________

If applicant is seeking registration as an MFT intern, please list graduate-level training in systemic theory and approach to couples and families issues:

____
____

B. Supervisor's Supervised Clinical Experience in counseling or marriage & family therapy:
LPC Supervisors – Number of years licensed in Oregon: _____

LMFT Supervisors – Number of years of post-graduate clinical experience: ______

C. STATE LICENSE / NATIONAL CREDENTIAL:

License Title		Issued by [state or national org.]
License No		
Original issue date		Expiration date

License Title		Issued by [state or national org.]
License No		
Original issue date		Expiration date

D. SUPERVISION TRAINING: Completed 30 clock hours of **post-masters training** in supervision theory and practice through master's workshops or post-master's graduate level academic coursework. List coursework, workshops or seminars.

Title of class / workshop / seminars	Sponsor of program	Date taken	No. of clock hrs

Supervision Services Agreement

SUPERVISOR AGREES TO:

Supervisor Initials

1. *Supervision Responsibilities*:

_____ Ensure compliance with Board's current published guidelines for experience, OAR 833-020-0050 through 0100.

_____ Provide ongoing, clinical supervision in a professional setting.

_____ Supervision will be face-to-face, except 10% can be telephone supervision.

_____ Discuss and review case notes, charts, records, and available audio or visual tapes for all clients.

_____ Review and closely supervise representative and problem cases providing special attention to assessments, treatment planning, ongoing case management, emergency intervention, record keeping, and termination.

_____ Focus on the appropriateness of the treatment plans.

_____ Monitor the appropriateness of clients served based on the applicant's therapeutic skill. Direct the applicant to refer clients who fall beyond their level of competence.

_____ Maintain confidentiality of all client and supervisory materials.

_____ *Review the Oregon licensing laws, administrative rules, and Code of Ethics with applicant.*

_____ Seek timely clarification/consultation from the Board if there are any problems or conflicts between commitment to agency, administrative supervisor, and client or other conflicts relating to the authority, dependency, or shared responsibility for fulfilling the responsibilities under this Plan.

2. *Reporting Responsibilities:*

_____ Establish and maintain a record-keeping system to track the direct client contact and supervision hours. Be prepared to provide supporting documentation verifying the accuracy of information reported, if requested by Board.

_____ Submit Six-month Evaluation Reports within one-month of end of reporting period.

_____ Notify the Board of any changes to supervisor's business address and phone number or change in credential status.

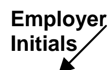
_____ ***Notify the Board immediately of any interruption or proposed termination of the plan.***

3. *Self Representation*:

_____ The Board does not confer a designated status of "Board-approved supervisor" and supervisors understand it is not legal to use this title.

Supervision Services Agreement [con't]

EMPLOYER / ADMINISTRATIVE SUPERVISOR ACCEPTS:



Employer Initials

_____ The conditions set forth in this plan.

APPLICANT AGREES TO:

Applicant Initials

_____ Abide by the Code of Ethics for Counselors and Therapists as defined in OAR 833, Division 60 and Oregon law and rules for LPCs and LMFTs.

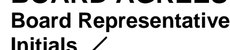
_____ Distribute a Professional Disclosure Statements to clients at the onset of therapeutic services.

_____ Establish and maintain a record keeping system to track the direct client contact and supervision hours.

_____ Submit requests to change or modify the "Work Plan" to Board prior to implementing changes.

_____ Ensure supervisor has authority to review all records, determine appropriateness of records, direct referrals of inappropriate clients, determine caseload, and report to Board.

BOARD AGREES TO:



Board Representative Initials

_____ Allow interns to indicate their status as a "registered professional counselor intern" or a "registered marriage and family therapy intern" working toward licensure. Interns may not claim to be eligible for licensure.

_____ Monitor Six-Month Evaluations, measuring them against the Intern Supervised Work Plan for compliance.

TERMINATION OF PLAN and/or REGISTRATION

Approval of this Plan will be terminated for the following reasons:

- Failing to obtain **prior approval** of the Board for changes in plan terms: place of practice[s]; supervisor[s], including license/certification status; ongoing client caseload and level of supervision.

Registration as an intern will be terminated for the following reasons:

- Failure to file a replacement plan within 90 days of the termination of supervisor.
- Failure to file a replacement plan within 90 days of the termination of a place of practice/employment.
- Failure to renew registration.
- Voluntary resignation or withdrawal of application.
- Exceeding five years from initial date of registration.

CERTIFICATION / SIGNATURES

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to follow the provisions set forth in this plan. I understand my responsibilities. I understand that knowingly making a false statement in connection with this proposed plan may result in disciplinary action. I have been given a copy of this Intern Supervised Work Plan, Pages 1 - 6.

____
Signature of Applicant Date

____
Signature of Clinical Supervisor Date

____
Signature of Administrative Supervisor/Employer Date

Instructions for Submitting Completed Form:

- ❑ Provide copies of this form for all signatories.
- ❑ Submit this form, with original signatures and a Professional Disclosure Statement for each work location.
- ❑ If submitted *separate from application*, mail to:

Board of Licensed Professional Counselors & Therapists
3218 Pringle Rd SE, #250/Salem, OR 97302-6312

For Board Use Only

Effective Date: ______/_______/_________. End Date: _____/_____/______.

Registered Interns have **5 years to complete supervised work experience** with the option of a 1-year extension.

Registration No: **R**_____________________

Signature of Authorized Board Representative: ____