



NORTH CAROLINA BOARD
of **LICENSED CLINICAL**
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
 FAX: 336-217-9450
 WEB: nblcmhc.org
 EMAIL: LCMHCinfo@nblcmhc.org

Supervision Contract

Indicate to which LCMHC Associate this contract applies:

LCMHC Associate Name: _____ LCMHCA (# _____)

INSTRUCTIONS: FORMS CAN BE MAILED, FAXED OR EMAILED

- PRINT** or **TYPE** using **BLACK** Ink to complete this supervision contract.
- ALL SECTIONS** must be completed or the supervision contract will be returned.
- The supervision contract should be mailed to the **NCBLCMHC Board Office at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417, or Faxed to: 1 (336)217-9450, or emailed: Supervision@nblcmhc.org**
- This supervision contract must be received and approved by the NCBLCMHC prior to initiation of supervision.

Date Received: _____
 Approved by: _____
 Date Approved: _____

I. GENERAL INFORMATION - (*Supervisor Information*)

Supervisor's Name (Last, First, Middle): _____ License Type/Number: _____
 Mailing Address (Name of Workplace, Mailing Address, City, State, Zip Code): _____ Issuance Date: _____
 _____ Business Phone: _____
 _____ Mobile Phone: _____
 Email Address: _____

II. SUPERVISION - *To be completed by supervisor. Clinical Supervision is defined in Rules .0208 through .0212.*

Is this an exempt setting (school, university, government agency)? Yes No

Location of Supervision— provide name of workplace, physical address and a contact phone number:

Physical Address (Street, City, State, Zip Code): _____ Business Phone: _____

Modality of Supervision to be Used - each supervision session shall utilize at least one of the following (check all that apply):

- Live Observation/Supervision Co-therapy Audio Recording Video Recording

Frequency of Supervision (minimum one hour of individual or two hours of group supervision per 40 hours of counseling practice as defined in Rule .0208. At least three-quarters of the hours of clinical supervision shall be individual.):

The supervisee will receive a minimum of _____ hours of individual clinical supervision weekly biweekly monthly or
 a minimum of _____ hours of group clinical supervision weekly biweekly monthly

Explanation of hours (if necessary): _____

III. SUPERVISOR CREDENTIALING - *If proposed supervisor is a NC Licensed Clinical Mental Health Counselor Supervisor (LCMHCS), skip to signatures.*

The following documentation **must** be submitted with this Supervision Contract:

Official transcript documenting the equivalent of 3 semester graduate credits in clinical supervision from a regionally accredited institution of higher education or 45 contact hours of continuing education in clinical supervision as defined by Rule .0603(c).

I agree to assume responsibility for the clinical work and preparation of this supervisee and will be available for consultation with the Board or its committees regarding the supervisee's competence.

Supervisor's Signature: _____ Date: _____

I understand and will abide by the requirements and expectations of supervision and the standards of clinical practice as defined by the Board.

Supervisee's Signature: _____ Date: _____