South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialists

Confirmation of Clinical Supervision of Post-master's Client Contact in Counseling

REQUIRED (see items 3 and 4 below)

1. Please print or type. This blank form may be photocopied for distribution if you have more than one supervisor.
2. This form must be signed by the licensed supervisor (or supervisor candidate, if applicable) and the applicant. Original signatures are required. This form may be photocopied for multiple supervisors.
3. Applicants who are required to be Interns should return this completed form after the completion of the two-year Intern licensure period. Mail to: Professional Counselors Board, PO Box 11329, Columbia, SC 29211-1329.
4. Applicants by endorsement should return this form to CCE, along with their other application materials.

Applicant Name (last, first, middle initial): _____

Social Security Number: _____

I have applied for licensure by the South Carolina Board of Licensed Professional Counselors. I am required to provide documentation of a minimum of 150 hours of supervision with a Licensed Professional Counselor Supervisor or Supervisor Candidate of which a minimum of 100 hours are required to be individual supervision and 50 of these hours can be either group or individual supervision. Please complete the information below and return the form to me.

_____ _____

Applicant's Signature Date

INFORMATION BELOW TO BE COMPLETED BY SUPERVISOR (not applicant)

Licensed Supervisor or Supervisor Candidate Verification Information

Check appropriate category: ☐ Supervisor ☐ Supervisor candidate

Name (last, first, middle initial): _____

Preferred Mailing Address: _____

_____

City: _____ State: _____ ZIP Code (+4): _____

Daytime Phone Number: _____

LPC/S Name: _____
(if supervision was completed by a Supervisor Candidate, indicate the Candidate's Supervisor)

LPC/S license number: _____ LPC/S license expiration date: _____

☐ I verify that the applicant was under my supervision at which time I critiqued the applicant's counseling and counseling-related skills based on one or more of the following forms of observation of the supervisee's counseling practice (check all that apply):

☐ Direct/live observation ☐ Live supervision ☐ Audio recordings
☐ Written clinical materials ☐ Video recordings ☐ Co-therapy

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Applicant's Employment

Name, address, telephone and type of work experience (Minimum of two years experience)	**Total # of years**	**From** month/year	**To** month/year

1. Confirmation of Supervised Clinical Experience of Direct Counseling Client Contact
(must reflect a minimum of 1,350 hours of supervised clinical experience)

Confirmation of 1,350 hours of direct client contact in counseling of individuals, couples, or groups under the supervision of a Licensed Professional Counselor Supervisor, Supervisor Candidate, or other qualified licensed mental health practitioner	**Total # of hours**	**From** month/year	**To** month/year

2. Confirmation of 150 hours of Post-Master's Immediate Supervision

Confirmation of hours of supervision by a Licensed Professional Counselor Supervisor or Supervisor Candidate (attach the supervision log)	**Total # of hours**	**From** month/year	**To** month/year
A. Individual (a minimum of 100 hours required to be individual supervision)			
B. Group			

RECOMMENDATION

I □ *recommend* □ *do not recommend* this applicant for licensure as a South Carolina Licensed Professional Counselor. Note: If you do not recommend this applicant/Intern, the Board requests that you send a separate letter directly to the Board office stating your reasons.

Additional Comments: _____

_____

_____

_____

Affidavit:

I attest that all information provided herein concerning supervision and work experience is accurate to the best of my knowledge and is in keeping with the Professional Counselors, Marriage and Family Therapists, and Psycho-Educational Specialist Practice Act. I understand that supervision for Licensed Interns and the duration for Intern licensure are for a period of not less than two years.

Signature of Supervisor:_____ Date:_____

(Original signature required)

Signature of Supervisor candidate (if applicable)_____ Date:_____

(Original signature required)