STATE OF OHIO COUNSELOR AND SOCIAL WORKER BOARD 77 SOUTH HIGH STREET, 16[™] COLUMBUS, OH 43266

PROFESSIONAL COUNSELOR TRAINING SUPERVISION AGREEMENT

Instructions to applicant:

- 1. Make additional copies of this form in the event you have more than one supervisor during the supervised practice time required for licensure.
- 2. This form must be filed at the <u>beginning</u> of the training experience.
- 3. Individuals who are registering experience with the Ohio Counselor and Social Worker Board must have a master's degree or Ph.D. in <u>Counseling</u>. Be certain your program meets this requirement as specified in board rule 4757-13-03. Degrees in psychology, social work and marriage and family therapy are not considered degrees in counseling.
- 4. Individuals must register practica and internships. Individuals with a master's degree in counseling must have a total of two years (3000 hours) which must be post PC (Professional Counselor). Individuals with a Doctorate must have two years of experience, one year (1500 hours) in an approved doctoral internship and one year (1500 hours) which must be competed after the degree is conferred.
- 5. During the training period, you must refer to yourself as a Counselor Trainee or Professional Counselor/Clinical Resident. You must hold a valid Professional Counselor License in order to use the PC/Clinical Resident title.
- 6. You must have one-hour face-to-face supervision for each 20 hours of work.
- 7. All supervised experience for licensure must be documented as specified in board rule 4757-17-01
- 8. Please attach proof of enrollment in a practicum or internship for approval.

9 LPC : PC 9 PCC

PAR	A: <u>To be completed b</u>	y superv	<u>visee</u>		SS#	·		
1.	Name of Applicant	First	Middle	Last		Daytime Phone		
2.	Address	Street				City	State	Zip
3.	Name of Supervisor					Title		
4.	Address of Supervisor					Phone		

5. Name, address and scope of practice of setting in which supervision is taking place:

6. Your supervisor's area(s) of competence in counseling (please attach professional disclosure statement of supervisor):

7.	Describe the duties you plan to perform. (For Clinical Residents Per rule 4757-13-03 (a) a minimum of 50 percent of the work consists of face-to-face client contact involving the delivery of clinical counseling services, which includes the diagnosis and treatment of mental and emotional disorders).									
8.	Dates of supervision at this setting	g: From	mo/yr	to	mo/vr					
	Please supply estimated ending date. We no longer approve ongoing status.									
	Total number of hours of supervise	d experience:								
9.	Total Work Hours (Maximum of 1500 hours in one year) Is there any part of this supervision being done to meet the internship requirements of a doctoral program? []Yes []No									
	If yes, indicate the university (please attach a copy of your student transcript verifying the actual beginning and ending of the semester/quarter.									
10.	Please list the license number, d	ate of issuance and expira	tion dates if y	ou are a PC.						
	PC/LIC #	Issuance Date		Expi	ration Date					
11.	Do you hold any other Licenses c	or certifications? [] Yes	[] No							
	LIC/CERT #	Issue Date		Expira	tion Date					

Memo of Understanding: I have read the counselor licensure law and understand the rules and regulations that pertain to Professional Counselor/Clinical Resident. I understand that I will have to submit the application and fees for the PCC after satisfactory completion of the supervision hours. I further understand that any person who knowingly makes a false statement on the registration form is guilty of falsification under section 2921.13 of the Ohio Revised Code, a misdemeanor of the first degree.

Signature of Supervisee

Part B: <u>To be completed by the Training Supervisor</u>

Ins	tructions to supervisor: After completing this form, please return it to the supervisee who is responsible for sending it to the Board.						
1.	Are you a Licensed Professional Counselor or a Licensed Professional Clinical Counselor?						
	[] Yes [] No If yes, what is your License # & Expiration Date						
2.	If you are not a licensed counselor, what license do you hold?						
	State License No						
3.	List your area (s) of professional competence:						
4.	Please describe the nature of the supervision to be provided:						
5.	Does the scope of your practice include the diagnosis and treatment of mental and emotional disorders? [] Yes [] No Briefly describe your experience in training supervision						
6.	I HAVE REVIEWED THE SUPERVISEE'S STATEMENTS. THEY (ARE) (ARE NOT) ACCURATE						
	Supervisor's Signature Date						

ATTACH THE SITE SUPERVISOR PROFESSIONAL DISCLOSURE STATEMENT TO THIS TRAINING SUPERVISION AGREEMENT