



## Supervision Contract

**Indicate to which LPC Associate this contract applies:**

LPC Associate Name: \_\_\_\_\_ LPCA (# \_\_\_\_\_)

**INSTRUCTIONS: FORMS MUST BE MAILED—NO FAXES OR EMAILS**

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this supervision contract.
2. **ALL SECTIONS** must be completed or the supervision contract will be returned.
3. The supervision contract should be mailed to the **NCBLPC Board Office at: NCBLPC, PO Box 77819, Greensboro, NC 27417**
4. This supervision **contract must be received and approved by the NCBLPC prior to initiation of supervision.**

Date Received: \_\_\_\_\_

Approved by: \_\_\_\_\_

Date Approved: \_\_\_\_\_

**I. GENERAL INFORMATION** - (*Supervisor Information*)

Supervisor's Name (Last, First, Middle): \_\_\_\_\_

(LPC, LCSW, etc.) \_\_\_\_\_

Mailing Address (Name of Workplace, Mailing Address, City, State, Zip Code):  
\_\_\_\_\_  
\_\_\_\_\_

License Type/Number: \_\_\_\_\_

Issuance Date: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

**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 Professional Counselor Supervisor (LPCS), 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: \_\_\_\_\_