Supervisee:       Title:       Program:

Supervisor: Rulondo T. Anderson Sr. Title: Licensed Professional Counselor, Qualified Clinical Supervisor Program: NCBLPC

Minimum Supervision Requirements/Frequency/Duration: 1 hour of individual Supervision or 2 hours of group supervision per 40 direct/indirect hours worked.

Supervision for the above supervisee will occur in the following manner (Check all that apply) Face to Face Phone Group Other *(specify):*

***Goal #1***

***Goal #2***

***Goal #3***

***Length and Termination:***

Start Date of Plan:       End Date of Plan:

***Review/Renewal:***

This plan will be reviewed annually and renewed bi annually.

***Supervision Rate:***       will pay Anderson counseling and Consulting Group, PLLC       per Individual and group supervision session. This rate will be paid at the beginning of every supervision session with the front desk receptionist. Supervision sessions cancelled less than 24 hours prior to the scheduled supervision session will be charged at the same rate.

**As a supervisee, I understand and agree to the following:**

1. I will actively participate in the methods of supervision.
2. I will take the necessary actions to accomplish stated supervision goals.
3. I will follow guidance given by my supervisor to complete the activities associated with my position.

Supervisee (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**As a supervisor, I understand and agree to the following:**

1. I will actively participate in the methods of supervision.
2. I will take the necessary actions to help my supervisee accomplish stated goal objectives.
3. I will offer guidance and supervision to my supervisee to complete the activities associated with his/her position.
4. I will assume the responsibility as a Supervisor to document the supervision in a clinical note.

Supervisor (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_