NORTH CAROLINA BOARD of LICENSED PROFESSIONAL COUNSELORS

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http://www.ncblpc.org

Verification of Supervised Professional Practice

[To be completed for LPC Applicants]

Indicate to which LPC Applicant this supervised professional practice applies:

Name: _____ (If applicable LPCA # _____)

Confidentiality Note - The information submitted in this contract is privileged and confidential, and is intended solely for use by the North Carolina Board of Licensed Professional Counselors. N.C.G.S. §132-1.2.

INSTRUCTIONS: FORMS MUST BE MAILED—NO FAXES OR EMAILS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of supervised professional practice. Person verifying supervised professional practice must be a qualified clinical supervisor as defined in Rule .0209.
2. **ALL SECTIONS** must be completed or the verification of supervised professional practice will be returned.
3. The verification of supervised professional practice should be enclosed in a sealed envelope and signed across the flap. Mail the signed and sealed envelope to the **NCBLPC Board Office at: NCBLPC, PO Box 77819; Greensboro, NC 27417**

I. GENERAL INFORMATION - *To be completed by person verifying supervised professional practice experience.*

Supervisor's Name (Last, First, Middle): Title:

Name of Agency where Supervised Professional Practice occurred: License Type and Number:

Issuance Date:

Mailing Address (Street and/or Box Number, City, State, Zip Code): Business Phone:

Email Address: Mobile Phone:

II. SUPERVISED PROFESSIONAL PRACTICE -

Supervision Period: _____ (month/day/year) to _____ (month/day/year)

Modality of Supervision Used (check all that apply):

☐ Direct (Live) Observation/Supervision ☐ Co-therapy ☐ Audio Recording ☐ Video Recording

Supervised Professional Practice and Clinical Supervision:

Supervised Professional Practice (as defined in Rule .0208): Total # Hours **Indirect** Counseling: _____

(no less than 8 hours per week, no more than 40 per week) Total # Hours **Direct** Counseling: _____

Individual Clinical Supervision (as defined in Rule .0210): Total # Hours: _____ *(no less than 1hr per 40 hrs worked)*

Group Clinical Supervision (as defined in Rule .0211): Total # Hours: _____ *(no less than 1hr per 40 hrs worked)*

I verify that the above information is accurate. The focus of the documented supervision sessions was based on raw data from clinical work which was made available to the supervisor through such means as direct (live) observation, co-therapy, audio and video recordings, and live supervision. The clinical supervision included a minimum of one hour of individual or group clinical supervision per 40 hours of counseling practice.

Supervisor's Signature: _____ Date: _____

Supervisee's Signature: _____ Date: _____