NORTH CAROLINA BOARD of LICENSED CLINICAL MENTAL HEALTH COUNSELORS

Final Supervision Report

Indicate to which LCMHC Associate this final supervision report applies:

LCMHC Associate Name: _____ LCMHCA (# _____)

INSTRUCTIONS: FORMS MUST BE FAXED, EMAILED, OR SUBMITTED VIA THE COUNSELOR GATEWAY

1. The Final Supervision Report should be submitted electronically via a request from the applicant in the Counselor Gateway, or by email from the supervisor to **supervision@ncblcmhc.org. If the form is submitted via email, it must come directly from the supervisor.** ***The supervisor's email must match the email address the Board has on file.***
2. **All sections must be completed, or the final supervision will be returned for revision/corrections.**
3. **Self-reporting of hours from the LCMHCA will *not* be accepted.**

I. GENERAL INFORMATION - *Supervisor's Information. Supervisor's Name (Last, First, Middle):*

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

Business Phone:

Email Address:

Mobile Phone:

II. FINAL SUPERVISION - *To be completed by the supervisor; dates must align with supervision contract approval dates and must be entered to be considered complete.*

Supervision Period: **Begin Date (mm/dd/yy)**_____ **End Date (mm/dd/yy)** _____

Modality of Supervision Used (check all that apply):

☐ Live Observation/Supervision ☐ Co-therapy ☐ Audio Recording ☐ Video Recording

Supervised Professional Practice and Clinical Supervision: (Please enter total hours of supervision)

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

(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 2hrs per 40 hrs worked)*

III. SUPERVISION SUMMARY - *To be completed by the supervisor. Please provide a summary of the supervision activities completed with this supervisee as well as identify strengths and potential deficits of the supervisee. Attach additional pages as needed.*

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Name of Applicant: *(Required)*_____

IV. PROFESSIONAL ASSESSMENT - *To be completed by supervisor.*

Please rate the applicant compared to other counselors you know on the characteristics listed below. Place a mark in the appropriate column for each characteristic using the following rating scale:

1 = Outstanding 2 = Above Average 3 = Average 4 = Below Average 5 = Not Qualified 6 = Cannot Evaluate

	1	2	3	4	5	6	Comments
Individual counseling skills							
Diagnostic skills							
Treatment planning implementation							
Appropriate referral making							
Appropriate record keeping							
Group counseling skills							
Personal integrity							
Consulting skills							
Insight into client's problems							
Ability to relate to co-workers							
Ability to be objective on the job							
Knowledge of assessment instruments							
Ethical conduct							
Concern for the welfare of clients							
Sense of responsibility							
Recognition of own limits							
Ability to keep material confidential							

V. REFERENCE - *To be completed by the supervisor.*

I ☐ recommend ☐ do not recommend this applicant for unrestricted licensure as an NC Licensed Clinical Mental Health Counselor.

Please note that the supervisor's recommendation should be based solely on the supervisee's clinical performance and demonstrated competencies, rather than on the amount of time or hours remaining to fulfill the 3,000-hour requirement for full licensure or any unrelated factors.

INITIAL (Required)_____

If you do not recommend this application for unrestricted licensure, please indicate below your reasons why:

_____

_____

_____

VI. VERIFICATION - *To be completed by the supervisor.*

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 live observation, co-therapy, audio and video recordings, and live supervision. The clinical supervision included a minimum of one hour of individual or 2 hours of group clinical supervision per 40 hours of counseling practice.

Supervisor's Signature: _____ **Date**: _____