NORTH CAROLINA BOARD of LICENSED CLINICAL MENTAL HEALTH COUNSELORS
P.O. Box 77819 | Greensboro, North Carolina 27417
Fax: (336) 217-9450
Email: complaints@ncblcmhc.org

Quarterly Supervision Report

To be filed for LCMHCA/LCMHC/LCMHCS ordered to receive supervision due to disciplinary action.

Revised 8/06/2025

LCMHCA/LCMHC/LCMHCS Associate Name: _____ **LCMHCA/LCMHC/LCMHCS License #** _____

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

1. The Quarterly Supervision Report can be submitted electronically via a request from the applicant in the Counselor Gateway, faxed, 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/LCMHC/LCMHCS under supervision will not be accepted.

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

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

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

Email Address: Mobile Phone:

II. SUPERVISION - *To be completed by the supervisor.*

Supervision Period: Year: _____ **For a Partial Quarter:** Begin Date (m/d/yr) _____ End Date (m/d/yr)_____

Full Quarters: ☐ Quarter 1 (1/1—3/31) ☐ Quarter 2 (4/1 - 6/30) ☐ Quarter 3 (7/1 - 9/30) ☐ Quarter 4 (10/1 - 12/31)

Supervised Professional Practice and Clinical Supervision:

I attest to the following:

Yes	No	
☐	☐	The supervisee received a minimum of 1 hour of individual or 2 hours of group clinical supervision per 40 hours of supervised professional counseling practice.
☐	☐	The focus of the supervision session was on raw data from clinical work that was made available to me through such means as live observation, co-therapy, audio and video recordings, and/or live supervision.

(Reminder: At least three-quarters of the hours of clinical supervision shall be individual.)

☐	☐	If individual clinical supervision was received, it was face-to-face supervision with 1 or 2 supervisees and me, for a period of no less than 1 hour of clinical supervision per session. ☐ **Check here if no individual supervision was received.**
☐	☐	If group clinical supervision was received, it was face-to-face supervision, between groups of supervisees (no more than 12 supervisees per group) and me, for a period of no less than 2 hours of clinical supervision per session. ☐ **Check here if no group supervision was received.**
☐	☐	The supervisee and I are maintaining a clinical supervision log of hours that includes the date, start and stop times; the modality of supervision provided; and notes on recommendations or interventions used during the supervision.
☐	☐	There are ethical and/or legal concerns regarding the supervisee that I believe the Board should be made aware of. If yes, please explain and cite the NC Statutes or ACA ethical codes that you feel have been violated. Please attach additional sheets if necessary.

_____

_____

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☐	☐	I acknowledge receipt and have reviewed the Consent Order outlining the disciplinary action against the licensee.

I verify that the above information is accurate. I am available for consultation with the Board or its committees regarding the supervisee's competence.

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

The Final Supervision Report form must be submitted to the Board within the timeframe specified in the consent order that necessitated the supervision.