



**NORTH CAROLINA BOARD**  
*of* **LICENSED CLINICAL**  
**MENTAL HEALTH**  
**COUNSELORS**

PHONE: 844-622-3572  
 FAX: 336-217-9450  
 WEB: [ncblcmhc.org](http://ncblcmhc.org)  
 EMAIL: [LCMHCinfo@ncblcmhc.org](mailto:LCMHCinfo@ncblcmhc.org)

**Supervision Contract**

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

LCMHC Associate Name: \_\_\_\_\_ LCMHCA (# \_\_\_\_\_)

**INSTRUCTIONS: FORMS ACCEPTED VIA EMAIL ONLY TO [supervision@ncblcmhc.org](mailto:supervision@ncblcmhc.org)**

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 unprocessed..**
3. The supervision contract should be emailed to [supervision@ncblcmhc.org](mailto:supervision@ncblcmhc.org).

**This supervision contract must be received and approved by the NCBLCMHC prior to initiation of supervision.**

**\*Hours accrued without a Board-approved contract on file will not be accepted\***

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

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

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

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

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

Supervisor's Name (Last, First, Middle): \_\_\_\_\_ License Type/Number: \_\_\_\_\_

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

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

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

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

**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 the proposed supervisor is an NC Licensed Clinical Mental Health Counselor Supervisor (LCMHCS), skip to signatures.*

**Supervision contracts will be approved only if the supervisor is Board-approved as a Qualified Supervisor (QS) or holds the LCMHCS credential. If this is the supervisor's initial contract submission, a QS or LCMHCS application must be submitted through the Counselor Gateway at <https://portal.ncblcmhc.org/>.**

**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: \_\_\_\_\_