NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
FAX: 336-217-9450
WEB: ncblcmhc.org
EMAIL: LCMHCinfo@ncblcmhc.org

Supervision Contract

Indicate to which LCMHC Associate this contract applies:

LCMHC Associate Name:_____ LCMHCA (#_____)

INSTRUCTIONS: FORMS CAN BE MAILED, FAXED OR EMAILED

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.
3. The supervision contract should be mailed to the **NCBLCMHC Board Office at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417, or Faxed to: 1 (336)217-9450, or emailed: Supervision@ncblcmhc.org**

Date Received: _____
Approved by: _____
Date Approved: _____

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

I. GENERAL INFORMATION - (*Supervisor Information)*

(LCMHC, LCSW, etc.) _____

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

Issuance Date: _____

Mailing Address (Name of Workplace, Mailing Address, City, State, Zip Code):

_____ Business Phone: _____

_____

Email Address: _____ Mobile Phone: _____

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

*The following documentation **must** be submitted with this Supervision Contract:*

Official transcript documenting the equivalent of 3 semester graduate credits in clinical supervision from a regionally accredited institution of higher education or 45 contact hours of continuing education in clinical supervision as defined by Rule .0603(c).

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: _____