STATE BOARD OF CLINICAL SOCIAL WORKERS **FORM 2**

PLAN OF SUPERVISION

Applicant Name:_______________________________________ [ ] Individual **and/or** [ ] Group

This portion is to be completed by Applicant and Clinical Supervisor. The applicant will receive written notification of Board approval. ***The Plan*** *(the time you can begin counting hours)* ***can only begin after the Board approves it.*** Plans need to reflect 24 months; more if part-time work. All Plan changes and modifications require prior Board approval before they can count.

CLINICAL SUPERVISOR INFORMATION (To be completed by the Supervisor)

Supervisor's Name ____ Degree(s)______________________________

License No. ____Initial Date:_____________________________

Employer____

Name Address Phone

- **Supervisor Requirements**: OAR 877-020-0012(8) requires LCSW's to have 2 years of post license experience and taken six hours of formal continuing education courses specific to Supervision and Ethics. These hours are good for 5 years from the completion date. A copy of the completion certificate documenting the CE must be on file in the Board office. The CE requirement must be met before beginning supervision with a CSWA.

____

Course/Workshop Name # of hours Date Taken

- How long have you known this supervisee? _________________ (Yrs) _________ (Mo.) Please describe **any** pre-existing relationship between you and the supervisee (use additional sheets of paper if necessary).__________________

____

To your knowledge, has the applicant ever been convicted of substance abuse, or any offense involving a controlled substance or alcohol, or of a felony in a state or federal court? [ ] Yes [ ] No If **yes**, please describe briefly.

____

- I have supervised the following Oregon MSWs seeking licensure: ____

____

Where will supervision take place? [ ] Supervisor's office [ ] Supervisee's office. Please specify._________________

The fee for supervision will be: ____________ (Specify per hour, week, month, or other arrangements). ____________

____

DESCRIPTION OF SUPERVISION **FORM 2**

INDIVIDUAL

Number of meetings ______________________________ per week or month for a total of ______________ hours over the duration of the 2 year Plan. (Example: One hour per week x 24 months = a total of 104 hours).

Dates of proposed Individual Supervision (From) __________________________ (To) ________________________

Brief description of the proposed Individual Supervision ____

____

GROUP

Number of meetings _______________________________ per week or month for a total of _________ hours over the duration of the Plan. (Example: Two meetings per month x 24 months = 48 hours).

Dates of proposed Individual Supervision (From) __________________________ (To) ________________________

Proposed number in Group (cannot exceed five supervisees) ___________

Brief description of proposed GROUP ____

____

****Counting of hours for this Plan may only begin on the date of approval by the Board. The Board usually meets on the second Tuesday of the month. All hours accrued prior to approval will be declined.**

RESPONSIBILITIES

This form identifies the responsibilities of the Associate, Clinical Supervisor, and Administrative Supervisor. Please read this form and initial on

APPLICANT

I understand that my title will be *Clinical Social Work Associate* and that I am **not** permitted, under Oregon Law, to be called or represent myself as a Licensed Clinical Social Worker.

I will follow the Code of Ethics for Social Workers as defined in Oregon Administrative Rules Chapter 877, Division 30.

I understand I must meet with my Supervisor at least two times a month for a minimum of 1 hour each meeting where my clinical work will be discussed, evaluated, and directed.

I understand it is my responsibility to obtain prior Board approval of **any change** to my Plan of Supervision and to keep the Board office informed of any name or address changes.

I understand that the Associate Plan cannot be completed in less than 2 years post MSW supervision and can take no longer than 5 years to complete each Associate Plan. Please reference Rule 877-020-0013(1)(a).

I will maintain client confidentiality at all times, including, during supervision.

RESPONSIBILITIES FORM 2

LCSW SUPERVISOR

I will closely review and supervise representative and problem cases with attention to diagnostic evaluation, treatment planning, ongoing case management, emergency intervention, record keeping, and termination.

I will review case records, billings, appointment book, and client population as appropriate.

I will determine appropriate client populations to be served and direct the Associate to refer inappropriate clients to other therapists.

I will maintain confidentiality of all client and supervisory materials.

I will review with the Associate the Oregon Laws and Administrative Rules related to the ethical principles of Clinical Social Workers, with specific attention to Division 30, the Code of Ethics.

I will submit **timely** Six-Month Evaluation reports to the Board of the Associate's progress and a final evaluation at the conclusion of the Plan.

I will communicate to the Board any interruptions, concerns, or proposed termination of the Plan.

ADMINISTRATIVE SUPERVISOR

I agree to facilitate and encourage the Supervision Plan for supervision between the applicant (Associate) and the Supervisor.

I agree to inform the Board of any changes in agency practices or policies which may adversely affect the successful completion of the Plan of Supervision.

ALL PLANS require signatures of the Clinical Supervisor (LCSW Supervisor) and Administrative Supervisor (Who you report to in the agency), the applicant. Be sure all signatures are in place before submitting your application. Unsigned forms will be returned thereby causing a delay in the approval process.

CERTIFICATION

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work with this Plan as described above.

SIGNATURES

Applicant ______________________________ Date ______________________

LCSW Clinical
Supervisor ______________________________ Date ______________________

Administrative
Supervisor ______________________________ Date ______________________