

**STATE BOARD OF CLINICAL SOCIAL WORKERS
SIX-MONTH SUPERVISION EVALUATION REPORT**

Form 7

Submit timely reports covering a full six months. Be sure to fill in all blanks with accurate totals. Cumulative totals should reflect totals for all reports including this one. Do not fax, but send originals, not photocopies, signed by all necessary parties. **Remember -- All Plan Changes must have prior approval by the Board. If your Plan requires a change, please contact the Board office at (503) 378-5735 and request the appropriate forms.**

ASSOCIATE'S NAME: _____

Report No. _____
(1, 2, 3, 4, Other, Final)

Reporting Period: _____ / _____
From To

Average face-to-face client hours received per week: _____

Total number of client hours for this 26 week reporting period: _____ Cumulative Total: _____

Total number of work hours for this 26 week reporting period: _____ Cumulative Total: _____

INDIVIDUAL SUPERVISION

TOTAL # of hours this report: _____ Cumulative Total: _____

Frequency of sessions: _____ Length of Sessions: _____

Describe your supervision sessions: _____

GROUP SUPERVISION

TOTAL # of hours this report: _____ Cumulative Total: _____ # of supervisees in group: _____

Frequency of sessions: _____ Length of Sessions: _____

Describe your supervision sessions: _____

EVALUATION (Use additional sheets of paper if needed)

1. What theory base of social work or therapy does the Associate use in their practice? _____

2. Does the Associate demonstrate an understanding of diagnosis and treatment planning? [] Yes [] No
If "No", indicate how this deficiency will be addressed: _____
