

PLAN OF SUPERVISION

Form 2

CSWA Name: _____ [] **Individual** and/or [] **Group**

CLINICAL SUPERVISOR INFORMATION (To be completed by the Supervisor)

Supervisor's Name _____ Degree(s) _____

Work Phone: _____ License #: _____ Initial _____ License Date _____

Employer: _____
Name Address City/State/Zip

Supervisor Requirements: OAR 877-020-0012(8) requires LCSW's to have 2 years of post license experience and taken at least six hours of continuing education courses specific to Supervision **prior** to supervision with a CSWA. These supervision continuing education hours are good for 5 years from the completion date. **Please list your supervision course below, even if you think we have a copy.**

Date Taken	Course/Workshop Name	# of hours
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How long have you known this supervisee? _____ (Yrs) _____ (Mo.) Describe briefly **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. [] Other

The fee for supervision will be _____ per hour _____ per week _____ monthly.

Please specify other arrangements: _____

DESCRIPTION OF SUPERVISION

FORM 2

****Counting of hours for this Plan of supervision may only begin after the date approved by the Board. The Board usually meets the second Tuesday of each month. All hours accrued prior to Board approval cannot be accepted.**

INDIVIDUAL

Supervision must occur at least 2 times a month with a supervisor identified in the plan as required in OAR 877-020-0009 (3) (d).

Number of times scheduled to meet with this Associate per week _____ per month _____

Proposed Individual Supervision is scheduled to begin **after** Board approval on _____
(No hours may count until the Board has approved the supervisee's Plan of Supervision)

Briefly describe the proposed supervision _____

GROUP

Proposed number in the Group _____ (cannot exceed five members in the group at any time)

Number of times scheduled to meet with the Associates per week _____ or per month _____

Proposed Group Supervision is scheduled to begin **after** Board approval on _____
(No hours may count until the Board has approved the supervisee's application)

Briefly describe the proposed supervision _____

ALL PLANS require signatures of the Clinical Supervisor (Your LCSW Clinical Supervisor) and Administrative Supervisor (The person you report to for work in the agency) and the Applicant.

CERTIFICATION

I certify by my signature below that the information provided in this document is true and correct to the best of my knowledge.

SIGNATURES

Applicant _____ **Date** _____

LCSW Clinical Supervisor _____ **Date** _____
This person could be both Clinical and Administrative supervisor. If so please sign on both lines.

Administrative Supervisor _____ **Date** _____
This is the person that supervises your work.

RESPONSIBILITIES

Please review the responsibilities regularly to remain within compliance with the Laws and Rules for Oregon Social Workers.

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 will meet with each supervisor and send in **timely** evaluation reports every 6 months to inform the Board of my progress. I will send in a final evaluation after all requirements have been met for the completion of the Plan of Supervision.

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

I understand it is my responsibility to obtain Board approval prior to any change to my Plan of Supervision and to keep the Board office informed of any name or address changes within 30 days of the change.

I understand that the Plan of Supervision cannot be completed in less than 24 months of post MSW supervision and no more than 60 months to complete each Plan. Please refer to Rule 877-020-0010(3) (A).

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

LCSW SUPERVISOR

I will closely review the Associates cases with attention to diagnostic evaluation, treatment planning, case management, emergency intervention, record keeping, and termination.

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

I will determine the appropriate client populations to be served by the Associate 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 ethical principles of Clinical Social Workers, with specific attention to Division 30, the Code of Ethics.

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 between the Applicant and the Clinical 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.