

**Board of Licensed Social Workers  
Clinical Social Work Associate  
Six Month Supervision Evaluation Report**

Six Month reports should be received within 30 days following the report due date. Incomplete forms will be returned. If you have more than one supervisor please have each complete a separate form.

ASSOCIATE'S NAME: \_\_\_\_\_

1 2 3 4 5 6 7  
8 9 10 Final  
Circle Report Number)

Reporting Period: \_\_\_\_\_ / \_\_\_\_\_  
From To

# of Work hours per week _____	# of Direct client hours per week _____
Number of client hours for this reporting period _____	Cumulative Total _____
Number of work hours for this reporting period _____	Cumulative Total _____

**INDIVIDUAL SUPERVISOR HOURS**

Number of hours this report: \_\_\_\_\_

Total # of Cumulative hours: \_\_\_\_\_

Number of meetings per week/month: \_\_\_\_\_  
(To remain in compliance with the rules, you must meet with each supervisor for at least 2 times per month for one hour each meeting over a full 6 month period to be able to count hours.)  
If you have special questions call the office to discuss.

**GROUP SUPERVISOR HOURS**

Number of hours this report: \_\_\_\_\_

Total # of Cumulative hours: \_\_\_\_\_

Number of meetings per eek/month: \_\_\_\_\_  
Number of supervisees in group: \_\_\_\_\_  
(No more than 5 supervisees are allowed in the group)

Briefly 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does the Associate understand the State Board of Licensed Social Worker's Code of Ethics and Rules of Licensure?  
[ ] Yes [ ] No Do you routinely discuss these two topics during your supervision? [ ] Yes [ ] No

4. Does the Associate routinely practice the Code of Ethics and Rules of Licensure? [ ] Yes [ ] No

5. How many case files did you review with the Associate? \_\_\_\_\_

6. Evaluate the strengths and weaknesses of the Associate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Describe the Associate's professional growth in the **last** six months: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Describe goals for the Associate's professional growth in the **next** six months: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Do you have any concerns about the Associate to practice or become licensed? [ ] Yes. [ ] No  
If Yes, briefly describe your concerns, and use additional paper as needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Supervisor's Signature**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Associate's Signature**  
(Associate's signature required to indicate that s/he has read the evaluation.)

\_\_\_\_\_  
Date

Mail this form to: State Board of Licensed Social Workers  
3218 Pringle Rd. SE, Suite #240  
Salem, OR 97302-6310

E-mail - [oregon.bls@state.or.us](mailto:oregon.bls@state.or.us)  
Questions Call 503-378-5735

**(Office Use Only)**  
Report reviewed by: \_\_\_\_\_  
Initial & Date