

REGISTERED INTERN SIX-MONTH SUPERVISION REPORT

Registered Intern: _____ OBLPCT Registration #: _____

E-Mail Address: _____

Individual Supervisor: _____ Group Supervisor: _____

Six-Month Reporting Period From: _____ to: _____
Month/Year Month/Year

EVALUATION

What theory base or therapy underlies the intern's practice? _____

Does the intern demonstrate an understanding of assessment & treatment planning? _____
Y N

If not, how are you addressing the deficiency? _____

Is the Intern distributing a Professional Disclosure Statement at onset of counseling? _____
Y N

Does the Intern understand Oregon's laws and rules regulating LPCs and LMFTs? _____
Y N

Do you routinely discuss the above with emphasis on the OAR Code of Ethics? _____
Y N

Evaluate the strengths and weaknesses of the intern at the present time:

Describe the Intern's professional growth in the last six months:

Describe the Intern's goals for professional growth in the next six months:

Do you have any concerns regarding this Intern being licensed? _____
Y N

Is this Intern competent and practicing at an acceptable standard within the profession as a whole?

REPORTED HOURS

Report # _____

DATES	DIRECT CLIENT CONTACT HOURS				SUPERVISOR HOURS			
Month/Year	Face to Face	LMFT Interns Couples & Families	Phone	CCH TOTAL	Individual	Phone	Group	SUPERVISION TOTAL
EXAMPLE: May, 2001	42	12	3	45	2		1.5	3.5
SUBTOTALS								

SIGNATURES

Individual Supervisor: _____

Date: ____/____/____

Printed Name: _____

Group Supervisor: _____

Date: ____/____/____

Printed Name: _____

Intern Signature: _____

Date: ____/____/____

[Sign to indicate report has been read]

⇒ Intern E-Mail address: _____

OFFICE USE ONLY

Notes: _____

Disposition: _____
Evaluator

____/____/____
Date

Approved Hours

____/____/____
Board Review Date