Oregon Board of Licensed Professional Counselors & Therapists

INTERN PLAN CHANGE REQUEST

Intern Name _____ LPC [ ] [ ] LMFT

Effective Date of Change: _____/_____/_____ Intern Number(s): R_____

I. CHANGE IN PLACE OF PRACTICE:
Attach revised PDS to this form (Supervisor(s) needs to sign below signifying knowledge of change)

[ ] Practice to Delete: _____

[ ] Practice to Add: [Requires new or revised Professional Disclosure Statement for approval]

New Practice Name: _____

Address: _____

Telephone(s) ( ) _____ E-Mail _____

Change Official Email Address [ ] Yes [ ] No

Beginning Date of **this** employment: ____ / ____ / ____ Job Title: _____

Describe client population and your duties _____

_____

_____

II. CHANGE IN SUPERVISOR:
(Supervisor(s) needs to sign below signifying knowledge of change)

[ ] Change in Supervisor[s] -- **Attach Form #7 and revised PDS to this form**
How many supervisors in your current "approved" plan? _____

Are you?
[ ] Replacing Existing Supervisor
[ ] Adding a Supervisor
[ ] Removing a Supervisor
[ ] Other _____

Current supervisor(s) _____ _____
Supervisor Supervisor

New supervisor(s) _____ _____
Supervisor Supervisor

Acknowledgment of Plan Change:

_____
Intern's Signature Date

_____ _____
Supervisor Signature Supervisor Signature

Mailing to: OBLPCT, 3218 Pringle Rd. SE, # 120, Salem, OR 97302-6312
Questions? [503] 378-5499 or E-Mail lpct.board@state.or.us

OFFICE USE ONLY
Plan Change Approved? [ ] YES [ ] Tentative [ ] NO Initial / Date _____

Six-Month Reporting Period: _____ to _____