INSTRUCTIONS
for
FORM #2 -- SUPERVISED WORK EXPERIENCE

APPLICANT INSTRUCTIONS

☐ Complete the Waiver on the first page for release of information by your direct clinical supervisor.

☐ The entire form must be completed and stapled together before submission.

☐ You may assist your supervisor in compiling the information, but the completed form must be returned to you in a sealed envelope with the Supervisor’s signature written across the seal.

SUPERVISOR INSTRUCTIONS

You have been authorized to provide information documenting the applicant’s experience as a counselor/therapist under your direct clinical supervision. This information will be part of a public record.

☐ Complete the entire form. Please take time to fully answer all the questions.

☐ Sign the work detail pages, and place the whole form in an envelope with the applicant’s name on the front.

☐ Seal the envelope. Sign across the sealed flap. Return the sealed envelope to the applicant.
FORM #2: POST-GRADUATE SUPERVISED WORK EXPERIENCE

LPC  LMFT

WAIVER

I, ________________________________________ [applicant authorize __________________________ [supervisor] to provide the Oregon Board of Licensed Professional Counselors & Therapists with all information of any kind which the professional experience reference deems relevant to my qualifications as applicant for licensure. I hereby release and discharge the reference from all claims arising out of the provision of such information.

Signature of Applicant           Date

1. Location and type of clinical supervision: [ ] On-site supervision: [ ] Individual [ ] Group
   [ ] Off-site supervision: [ ] Individual [ ] Group

2. Applicant’s practice setting:
   [ ] agency    [ ] private
   [ ] school practice
   [ ] institution
   Agency/Business: ________________________________
   Address: ________________________________
   City, ST, Zip: ________________________________

3. Applicant’s job title: ________________________________

4. Applicant’s counseling activities: ________________________________

5. You reviewed: [ ] case notes       [ ] charts       [ ] records
   [ ] audio or visual tapes     [ ] assessments and treatment plans

6. Your direct supervision of client counseling hrs took place: From: ________________  To: ________________
   Mo / Day / Yr     Mo / Day / Yr

7. ________ Total number of client contact hours of counseling [LPC] or therapy [LMFT] for which you provided clinical supervision at this setting during this time -- as set forth in the attached detailed pages.

8. ________ Total number of supervision hours you provided.
   Individual Supervision Hrs: ________ Length and Frequency of Meetings: ________________________________
   Group Supervision Hrs: ________ Length and Frequency of Meetings: ________________________________
   Group Size: ______

9. Did other people provide supervision for the same client contact hours listed in #6 above? [ ]Yes [ ]No
   If yes, please list other supervisors and indicate whether the supervision was individual or group supervision.

10. Did this applicant perform clinical work adequately? [ ]Yes [ ]No
    If no, explain on a separate sheet.
    Do you know of any reason why the applicant should not be licensed? [ ]Yes [ ]No
    If yes, please explain.
Supervisor Credentials
Fill in the following information about yourself at the time the supervision was taking place.

1. Graduate degree: ___________________ In: ___________________ Date degree was issued: ____________
   From [institution]: ____________________________ [MA/ MS] [ subject ]
   For LMFT applicants only: List graduate courses/other training [but NOT experience] in marriage and family
treatment specialties: ____________________________________________________________
   _________________________________________________________________________
   _________________________________________________________________________

2. Mental health profession license, national supervisor credential, or national counselor / clinical supervisor
certification held.
   Date Issued: ____________________________ Date Issued: ____________________________
   ____________________________ ____________________________

3. After completing your mental health graduate training:
   You have counseled for how many years under clinical supervision: ______
   You have counseled for how many years before you began supervising the applicant: ______

4. List at least 30 clock hours of post-masters training in supervision [NOT experience]. List workshops, seminars,
   graduate level class, and / or doctoral studies. Be prepared to document if requested by Board.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TITLE &amp; SPONSOR</th>
<th>CONTENT</th>
<th>CLOCK HRS</th>
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I attest the information I have provided the Board is true, and I take responsibility for the information I have
provided.

Signature of Supervisor ____________________________ Date ____________

Supervisor’s Name, Address, and Telephone Number [please print legibly]:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
List direct client counseling hours and formal supervision meetings. [Indicate if estimates are used rather than actual hours from recorded logs. The Board prefers actual hours, so please explain in writing how estimates were determined if used.]

<table>
<thead>
<tr>
<th>Client Contact Period</th>
<th>Direct Client Contact Hours</th>
<th>Supervision Dates and Hours</th>
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<tbody>
<tr>
<td></td>
<td>Face to Face</td>
<td>By Phone</td>
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</tbody>
</table>

**EXAMPLE:**

**May 2001**

|                     |      |      | 45 | 2 | 1.5 | 3.5 |

**SUB TOTALS**

Photocopy additional blank detail forms as needed.