Oregon Board of Licensed Professional Counselors & Therapists
3218 Pringle Road SE, Ste. 120 | Salem, OR 97302
lpct.board@mhra.oregon.gov | (503) 378-5499

POST-GRADUATE SUPERVISED WORK EXPERIENCE FORM

This form is to be completed and signed by the supervisor who provided direct clinical supervision to the applicant. It must be returned by the supervisor directly to the Board. Applicants may assist the supervisor in compiling information, but the fully completed form must be returned by the supervisor.

Complete this form only for supervised experience that occurred after the applicant's degree conferral, and that has actually been completed as of the date you sign this form (do not include expected hours).

Applicant's Name: _____

SUPERVISOR'S INFORMATION

Supervisor Name: _____ Title: _____

Phone: _____ Email: _____

License Type & Number: _____ Original Issue Date: _____

APPLICANT'S EXPERIENCE SUPERVISED BY SUPERVISOR

Practice Site #1

Practice/Agency Name: _____

Practice Address: _____

Applicant's Title During Experience: _____

Dates of Supervision: _____ to _____ Hours Worked per Week: _____

Total Clock Hours of *Direct Client Contact** performed by Applicant under your supervision: _____

► Out of the Total Clock Hours above, how many hours did Applicant spend working with couples and families in the same session?: _____

Briefly describe Applicant's client population and duties:

_____

_____

Practice Site #2 *(if applicable)*

Practice/Agency Name: _____

Practice Address: _____

Applicant's Title During Experience: _____

Dates of Supervision: _____ to _____ Hours Worked per Week: _____

Total Clock Hours of *Direct Client Contact** performed by Applicant under your supervision: _____

► Out of the Total Clock Hours above, how many hours did Applicant spend working with couples and families in the same session?: _____

Briefly describe Applicant's client population and duties at Practice Site #2:

_____

_____

* *Direct client contact hours* means only those clinical experience hours that are therapeutic or a combination of assessment and subsequent therapeutic interactions.

CHARACTER & FITNESS

1) Was Applicant's experience obtained in compliance with the laws and rules of the jurisdiction in which the experience was completed? If no, please explain. ☐ Yes ☐ No

_____

_____

2) Would you be willing to employ Applicant, if there was an opening in your organization/practice? If no, please explain. ☐ Yes ☐ No

_____

_____

3) Is Applicant a credit to the profession based on ethical conduct, personal character, and technical competence? If no, please explain. ☐ Yes ☐ No

_____

_____

4) Are you aware of any reasons why Applicant should not be licensed to practice professional counseling or marriage and family therapy in the State of Oregon? If yes, please explain. ☐ Yes ☐ No

_____

_____

5) Is there any other information about Applicant that you believe should be provided to the Board of Licensed Professional Counselors and Therapists? If yes, please explain. ☐ Yes ☐ No

_____

_____

ATTESTATION AND SIGNATURE

I attest that I have answered all the questions without reservation, and that all of the information provided by me herein is true and correct.

_____ _____

Clinical Supervisor Date

Supervisor: Please return this fully completed and signed form directly to OBLPCT | 3218 Pringle Rd. SE, Ste. 130 | Salem, OR 97302-6309 or to lpct.board@mhra.oregon.gov.