

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) must 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 _____

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

Describe client population and your duties _____

II. CHANGE IN SUPERVISOR:

(Supervisor(s) must 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 Signature _____

Supervisor Signature _____

Mail to: OBLPCT, 3218 Pringle Rd. SE, # 250, 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 _____