



HEALTH LICENSING OFFICE
Behavior Analysis Regulatory Board

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Interventionist Supervision Agreement (Page 1 of 2)

This form identifies the responsibilities of the Behavior Analysis Interventionist and the supervising Behavior Analyst, Assistant Behavior Analyst, or Licensed Health Care Professional. Both the applicant and supervisor must sign this document. A copy this agreement must be submitted to the HLO and provided to the parent or guardian of each of the interventionist's clients, and must be maintained by the Registered Interventionist for a period of at least five years as outlined in OAR 824-040-0010.

1. Interventionist Information

INTERVENTIONIST'S NAME: LAST	FIRST	MIDDLE INTIAL	DATE
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2. Supervisor Information

SUPERVISOR'S NAME: LAST	FIRST	MIDDLE INTIAL	DATE
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SUPERVISOR'S PROFESSIONAL LICENSE:

BEHAVIOR ANALYST ASSISTANT BEHAVIOR ANALYST

HEALTH CARE PROFESSIONAL (HCP) - TITLE: _____

SUPERVISOR'S BARB or HCP LICENSE #

EMPLOYER:

EMPLOYER PHYSICAL ADDRESS:

CITY:

STATE:

ZIP:

PROPOSED DATES OF SUPERVISION:

FROM:

TO:

WHERE WILL SUPERVISION TAKE PLACE? SUPERVISOR'S OFFICE INTERVENTIONIST'S OFFICE

OTHER: EXPLAIN

NAME OF FACILITY WHERE SUPERVISION WILL TAKE PLACE:

ADDRESS OF FACILITY (PHYSICAL LOCATION):

CITY:

STATE:

ZIP:

Interventionist Supervision Agreement (Page 2 of 2)

3. Responsibilities

Interventionist agrees that:

My title will be **Registered Behavior Analysis Interventionist** and that I am **not** permitted, under Oregon Law, to be called or represent myself as a Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, or Licensed Health Care Professional;

I will provide a copy of this signed agreement to the Health Licensing Office, and to each client's parent or guardian;

I will complete a competency assessment with one of my supervisors and retain a copy of the assessment in my files;

I will maintain a log of ongoing training and supervision on the form available on the Office's website, or on the supervisor's form that contains all the same information;

I will notify the Office in writing within 10 business days if they are no longer being supervised or has a change in supervision;

I will follow the Standards of Practice, Professional Methods and Procedures as specified in **OAR 824-60-0010**, and understand that failure to comply with these standards may constitute unprofessional conduct which is subject to discipline under **ORS 676.805** and **ORS 676.992**; and

I will provide any and all information to my supervisor, and to the HLO, to ensure that protocols set-forth in Oregon Administrative Rules regulating my duties, responsibilities and services as an interventionist and as a supervisee, including the protocols set-forth in this agreement for the provision of my supervision, and agree to obtain prior approval of any modifications to this agreement.

By signing below, I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work under this supervision agreement as described above.

Interventionist Signature:

Date:

Supervising Behavior Analyst, Assistant Behavior Analyst, Health Care Professional agrees that:

I will ensure that a copy of this agreement is provided to the parent or guardian of each client receiving independent service delivery from the interventionist that is subject to this agreement;

I will complete a competency assessment on the interventionist subject to this agreement;

I will provide ongoing training and supervision to the interventionist after beginning independent client service delivery;

I will maintain oversight, as defined in OAR 824-010-0005(12), of the interventionist for a minimum of two hours prior to independent service delivery with any new client, which can be met through training;

I will provide a combination of direct and indirect supervision for at least 5 percent of the interventionist's service hours;

I will provide direct supervision at least once per calendar month in the months when services were provided; and

I will evaluate the interventionist subject to this agreement at least once a year after initial competency assessment on the form available on the Office's website or on another evaluation form with the same information.

By signing below, I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work under this supervision agreement as described above.

Supervisor Signature:

Date: