SUPERVISION REPORT FORM

Return to the Board by mail, fax, or email to:

Bureau of Professional Licensure
6200 Park Ave.
Suite 100
Des Moines, IA 50321-1270

Fax: 515-281-3121
Email: plpublic@idph.iowa.gov

MHC/MFT supervision rules: 645 IAC 31.7

SW supervision rules: 645 IAC 280.6

Supervisee's Name:_____ License #:_____

Supervisee's mailing address:_____

Supervisee's daytime phone number:_____

Supervisee's email address:_____

Date the supervisee initially began supervision with any supervisor:_____

Agency/Institution of supervised clinical experience:_____

Supervisor's Name:_____

Supervisor's license type:_____ License #:_____

Supervisor's mailing address:_____

Supervisor's daytime phone number:_____

Supervisor's email address:_____

The following must be completed by the supervisor:

Select the reason for submission of this form:

The supervisee has completed all requirements of the supervised clinical experience ☐

The supervisee is ceasing supervision with the identified supervisor ☐

Start date of supervision: _____

End date of supervision: _____

Number of hours of practice completed by the supervisee under your supervision: _____

Number of hours of direct client contact completed by the supervisee under your supervision: _____
(*The supervised clinical experience must consist of at least 3,000 hours of practice, with at least 1,500 hours of direct client contact*)

Total number of direct supervision hours: _____

Number of direct supervision hours obtained through group supervision: _____

For supervisees who started supervision on or after July 20, 2022, number of direct supervision hours that included direct observation of client interaction (live or recorded): _____
(*The supervised clinical experience must consist of at least 110 hours of direct supervision equitably distributed throughout the supervised clinical experience, including at least 24 hours of live or recorded direct observation of client interaction. A maximum of 50 hours of direct supervision may be obtained through group supervision*.)

Did the supervised clinical experience involve performing psychosocial assessments, diagnostic practice using the current edition of the DSM, and providing treatment, including the establishment of treatment goals, psychosocial therapy using evidence-based therapeutic modalities, and differential treatment planning? _____

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Did the supervised clinical experience prepare the supervisee for independent practice, including training on practice management, ethical standards, legal and regulatory requirements, documentation, coordination of care, and self-care? _____

_____

_____

_____

Did the supervisee practice in a competent manner? _____

Did the supervisee adhere to the Board's rules, including the applicable ethical code? _____

If this supervision form is being submitted because the supervisee has completed all requirements of the supervised clinical experience, do you recommend this supervisee for independent licensure?

_____

Please attach an explanation for any "no" answers.

_____

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_____ _____

Supervisor's Signature Date