IOWA | Department of Inspections, Appeals, & Licensing

Supervision Report

Board of Behavioral Health Professionals

Supervisee Information

Note: Supervisees are not permitted to operate their own private practice or to operate a group practice consisting solely of supervisees.

Supervisee's Name: _____ License #: _____

Supervisee's Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Date Supervisee Initially Began Supervision with Any Supervisor: _____

Agency/Institution of Supervised Clinical Experience: _____

Supervisor Information

To be completed by the supervisor.

Supervisor's Name: _____ License Type: _____

License #: _____ Supervisor's Phone Number: _____

Supervisor's Email Address: _____

Supervisor's Mailing Address: _____

City: _____ State: _____ Zip: _____

Supervision Report

To be completed by the supervisor. Please report only your supervision hours.

Select the reason for the submission of this form:

- ☐ Supervisee has completed all requirements of the supervised clinical experience.
- ☐ Supervisee is ceasing supervision with the identified supervisor.

Start Date of your Supervision (MM/DD/YYYY): _____

End Date of your Supervision (MM/DD/YYYY): _____

Total direct client contact hours under your supervision: _____

\+

Total indirect practice hours under your supervision: _____

=

Total practice hours: _____

Total individual one to one supervision hours: _____

\+

Total group supervision hours: _____

=

Total supervision hours: _____

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Did the supervisee practice in a competent manner? ☐ Yes ☐ No

Did the supervisee adhere to the board's rules, including the applicable ethical code? ☐ Yes ☐ No

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?
☐ Yes ☐ No

Please attach an explanation for any “no” answers.

_____ _____
Supervisor’s Signature Date

Dept. of Inspections, Appeals, & Licensing
Board of Behavioral Health Professionals
6200 Park Avenue, Suite 100
Des Moines, IA 50321-1270
Email: pld-licensure@dial.iowa.gov
Phone: 515-281-0254