Supervision Report

Board of Behavioral Health Professionals

MHC/MFT Supervision Rules: 481 IAC 891.7(154D)
SW Supervision Rules: 481 IAC 895.6(154C)

Supervisee Information

Supervisee's Name: _____ License #: _____

Supervisee's Mailing Address: _____

Supervisee's Email Address: _____

Supervisee's Daytime Phone Number: _____

Date supervisee initially began supervision with any supervisor: _____

Agency/Institution of Supervised Clinical Experience: _____

Supervisor Information

Supervisor's Name: _____ License Type: _____

License #: _____ Supervisor's Daytime Phone Number: _____

Supervisor's Email Address: _____

Supervisor's Mailing Address: _____

Supervision Report

The following must be completed by the supervisor.

Select the reason for 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 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: _____ Note: 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: _____

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

Return the completed form by mail, fax, or email to:

Dept. of Inspections, Appeals, & Licensing
Board of Behavioral Health Professionals
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Des Moines, IA 50321-1270
PLpublic@idph.iowa.gov; Fax: 515-281-7969