

Supervision Plan

Board of Behavioral Health Professionals

You must submit a completed supervision plan form before beginning supervision.

Supervi	isee I	nform	ation

Supervisee's Name:		License #:	
Supervisee's Mailing Address:			
City:	State:	Zip:	
Email Address:	Phone Number:		
Agency/Institution of Supervised Clinical	l Experience:		
Address of Agency/Institution:			
City:	State:	Zip:	
supervision. ● You may utilize a maximum o	of four supervisors at any	given time. You must notify each	
supervisor of all other supervisor Supervisor Information To be completed by the supervisor.	rs utilized.	,	
Supervisor Information		cense Type:	
Supervisor Information To be completed by the supervisor.	Li		
Supervisor Information To be completed by the supervisor. Supervisor's Name:	Li Supervisor's Phone Nun	cense Type:	
Supervisor Information To be completed by the supervisor. Supervisor's Name: License #:	Li Supervisor's Phone Nun	cense Type:	
Supervisor Information To be completed by the supervisor. Supervisor's Name: License #: Supervisor's Email Address:	Li Supervisor's Phone Nun	cense Type:	
Supervisor Information To be completed by the supervisor. Supervisor's Name: License #: Supervisor's Email Address: Supervisor's Mailing Address:	Li Supervisor's Phone Nun State:	cense Type:nber:	

Are you on the list of board-approved supervisors? Check the board's website. Yes \(\subseteq \) No \(\subseteq \) If no, submit proof of completion of a 6-hour continuing education course in supervision or one graduate-level course in supervision with this form.				
Plan for Supervision Answer the following questions together.				
Anticipated Start Date of Supervision (Must be in the future (MM/DD/YYYY)):				
Anticipated End Date of Supervision (Min. two years of supervision):				
Approximately how many hours per week will the supervisee work under this plan?				
Approximately how many hours per week will the supervisee have direct client contact?				
What is the planned frequency and duration for direct individual supervision?				
What is the planned frequency and duration for direct group supervision?				
How will you direct supervision? In-Person \square Videoconference \square Both \square				
Describe the goals and objectives for supervision:				
Describe which of the required content areas this supervision plan intends to cover:				
Note: The supervised clinical experience must 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. The supervised clinical experience must prepare the supervisee for independent practice and must include training on practice management, ethical standards, legal and regulatory requirements, documentation, coordination of care, and self-care. If the supervisor does not work for the same agency/institution as the supervisee, describe how the supervisor will have access to the supervisee's clinical records:				
If the supervisee will also be utilizing other supervisors, describe your plans for coordinating with the other supervisors:				

Certification of Supervision Plan

I certify that I have read and understand the rules regarding supervised clinical experience, and that the practice detailed herein meets the requirements found in those rules. I also certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare, under penalty of perjury, that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the supervised clinical experience. I also understand that this application is a public record and is open for public inspection in accordance with Iowa Code Chapter 22. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

Supervisor's Signature	Date
Supervisee's Signature	 Date

Dept. of Inspections, Appeals, & Licensing

Board of Behavioral Health Professionals 6200 Park Avenue, Suite 100 Des Moines, IA 50321-1270 Email: plpublic@idph.iowa.gov

Phone: 515-281-0254