Supervision Plan

Board of Behavioral Health Professionals

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

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

Supervisee Information

Supervisee's Name: _____ License #: _____

Supervisee's Mailing Address: _____

Supervisee's Email Address: _____

Supervisee's Daytime Phone Number: _____

Agency/Institution of Supervised Clinical Experience: _____

Address of Agency/Institution: _____

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

Will you also be utilizing another supervisor? ☐ Yes ☐ No

If yes, you must submit a separate supervision plan form for each supervisor prior to beginning supervision. You may utilize a maximum of four supervisors at any given time. You must notify each supervisor of all other supervisors utilized.

Supervisor Information

To be completed by the supervisor.

Supervisor's Name: _____ License Type: _____

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

Supervisor's Email Address: _____

Supervisor's Mailing Address: _____

Does the supervisor work at the supervisee's agency/institution identified above? ☐ Yes ☐ No

If no, provide practice location information: _____

Do you have a minimum of three years of independent practice? ☐ Yes ☐ No
If no, you cannot serve as a supervisor.

Are you on the list of board-approved supervisors? ☐ Yes ☐ No
Check the board's website. 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): _____

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? _____
Important! The supervised clinical experience must consist of at least 3,000 hours of practice, with at least 1,500 hours of 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 ☐ Videoconference ☐ Both

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

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

Dept. of Inspections, Appeals, & Licensing
Board of Behavioral Health Professionals
6200 Park Avenue, Suite 100
Des Moines, IA 50321-1270
PLpublic@idph.iowa.gov; Fax: 515-281-7969