Name of LPC supervisee: ____

Minnesota Board of Behavioral Health and Therapy
LPC Verification of Completion of a Supervision Plan

1. This form is to be completed by the supervisor. The supervisor must submit this *completed*, *original*, *signed* form *directly* to the Board office at the address listed below. (This form may not be completed by or submitted by the supervisee.)

2. The supervisor must complete this form with information pertaining only to the portion of supervision that they supervised.

3. This form is to be completed only when the approved supervision plan of a licensee of the Board has been completed according to Minn. Stat. sec. 148B.53, subd. 1(a)(4) and Minn. Rules part 2150.5010.

4. If the licensed supervisee received supervised experience at more than one setting or with more than one supervisor, this form must be completed by each supervisor and/or for each setting.

5. Upon review of the information, the Board will notify the supervised licensee whether supervision requirements have been completed, in whole or in part. The supervised licensee may not discontinue supervision until he/she has been notified by the Board in writing that he/she may practice independently.

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1. Name of Supervisee: ____ License No: LPC____________

2. Name of Supervisor: ____

3. Name of supervision location (Business): ____

4. Address of supervision location: ____

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5. **Date Supervision:** ***Began***: ___________________________ ***Ended***: ___________________________
Between these dates, the supervisee completed the following under my supervision:
6. Hours **worked (i.e. professional practice)** per week (list hours):
7. **Supervision** hours I provided to the supervisee per week (list hours):
8. **I** provided the following supervision to the supervisee (circle): **Individual** **Group** **Both**
9. Total hours of supervised practice (tally of supervisee's **work** hours between above dates):
10. Total hours of supervision (tally of all **supervision** hours between above dates; separately list number of individual supervision hours and number of group supervision hours):

11. Names of other supervisors that provided supervision to the supervisee named above, for his/ her LPC professional supervision:

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Name of LPC supervisee: _______________________________________

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Supervisor: Please ***initial*** *the following certifying statements (if you do not agree to initial any of these statements please leave that item blank and explain in a separate written statement the reasons you are in disagreement with each one left unsigned):*

I certfy that the supervised professional practice of the licensed supervisee listed above complied with Minnesota Rule 2150.5010, subp. 4, including (please **initial** each):

	12. The content of supervision included professional counseling knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.
	13. The content of supervision included the standards of practice and ethical conduct, with particular emphasis given to the professional counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.
	14. The content of supervision included the supervisee's permissible scope of practice, as defined by Minnesota Statutes, section 148B.50, subd. 5.
	15. Supervision was obtained at the rate of 2 hours of supervision per 40 hours of professional practice.
	16. Supervision was evenly distributed over the course of the supervised professional practice
	17a. 75% to 100% of supervision was received in person.
	17b. 0% to 25% of supervision was received via telephone or audio or audiovisual electronic device.
	18a. 50% to 100% of supervision was done on an individual basis (one-to-one).
	18b. 0% to 50% of supervision was done in a group setting.
	19. (Initial if full 2,000 hours completed under your oversight) Supervision was completed in no fewer than 12 consecutive months and no more than 36 consecutive months.
	20. I certify that the work completed under my supervision was satisfactory.

21. I, the undersigned, have read and agree that the supervision was conducted as described above, and that the information contained therein is true and correct to the best of my knowledge.

Supervisor's Signature: ____ Date: ____________________

Please complete this form and mail directly to:
The Minnesota Board of Behavioral Health and Therapy
335 Randolph Avenue, Suite 290
St. Paul, MN 55102

Updated: August 2021