



# North Carolina Board of Licensed Professional Counselors Verification of Supervised Professional Practice

[To be completed for LPC Applicants for supervised professional practice not already reported Quarterly Reports]

Indicate to which LPC Applicant this supervised professional practice applies:

Name: \_\_\_\_\_ (If applicable LPCA # \_\_\_\_\_ )

**Confidentiality Note** - The information submitted in this contract is privileged and confidential, and is intended solely for use by the North Carolina Board of Licensed Professional Counselors. N.C.G.S. §132-1.2.

## VERIFICATION OF SUPERVISED PROFESSIONAL PRACTICE INSTRUCTIONS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of supervised professional practice. Person verifying supervised professional practice must be a qualified clinical supervisor as defined in Rule .0209.
2. **ALL SECTIONS** must be completed or the verification of supervised professional practice will be returned.
3. The verification of supervised professional practice should be enclosed in a sealed envelope and signed across the flap. Mail the signed and sealed envelope to the **NCBLPC Board Office at: NCBLPC, PO Box 1369, Garner, NC 27529**

### **I. GENERAL INFORMATION** - *To be completed by person verifying professional experience.*

Name (Last, First, Middle):

Title:

Name of Agency where Supervised Professional Practice Occurred:

License Type and Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code):

Business Phone:

Email Address:

Mobile Phone:

### **II. VERIFICATION OF SUPERVISED PROFESSIONAL PRACTICE** - *To be completed by person verifying supervised professional practice.*

Are you a Qualified Clinical Supervisor as defined in Rule .0209? Yes \_\_\_\_\_ No \_\_\_\_\_

Supervision Period: \_\_\_\_\_ (month/day/year) to \_\_\_\_\_ (month/day/year)

Modality of Supervision Used (check all that apply):

Direct (Live) Observation/Supervision  Co-therapy  Audio Recording  Video Recording

Hours and Type of Supervised Professional Practice and Clinical Supervision:

Total # of hours of Supervised Professional Practice (as defined in Rule .0208): Indirect: \_\_\_\_\_ Direct: \_\_\_\_\_

Total number of hours of Individual Clinical Supervision (as defined in Rule .0210): \_\_\_\_\_

Total number of hours of Group Clinical Supervision (as defined in Rule .0211): \_\_\_\_\_

I verify that the above information is accurate. The focus of the documented supervision sessions was based on raw data from clinical work which was made available to the supervisor through such means as direct (live) observation, co-therapy, audio and video recordings, and live supervision. The clinical supervision included a minimum of one hour of individual or group clinical supervision per 40 hours of counseling practice.

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_