NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS
P.O. Box 77819 | Greensboro, North Carolina 27417

Quarterly Supervision Report

To be filed for LCMHCAs with approved supervision contracts.

Indicate to which LPC Associate this quarterly supervision report applies:

LCMHC Associate Name:_____ LCMHCA (# _____)

INSTRUCTIONS:

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this quarterly supervision report.
2. **ALL SECTIONS** must be completed or the quarterly supervision report will be returned.
3. The quarterly supervision report should be mailed to Board Office at**: NCBLCMHC, PO Box 77819, Greensboro, NC 27417**

I. GENERAL INFORMATION - *(Supervisor Information.)*

Supervisor's Name (Last, First, Middle):

Mailing Address (Name of Workplace, Street and/or Box Number, City, State, Zip Code): Business Phone:

Email Address: Mobile Phone:

II. SUPERVISION - *To be completed by supervisor.*

Supervision Period: Year: _____ **For a Partial Quarter:** Begin Date (m/d/yr) _____ End Date (m/d/yr)_____

Full Quarters: ☐ Quarter 1 (1/1—3/31) ☐ Quarter 2 (4/1 - 6/30) ☐ Quarter 3 (7/1 - 9/30) ☐ Quarter 4 (10/1 - 12/31)

Supervised Professional Practice and Clinical Supervision:

I attest to the following:

Yes	No	
☐	☐	The supervisee received a minimum of 1 hour of individual or 2 hours of group clinical supervision per 40 hours of supervised professional counseling practice.
☐	☐	The focus of the supervision session was on raw data from clinical work that was made available to me through such means as: live observation, co-therapy, audio and video recordings, and/or live supervision.

(Reminder: At least three quarters of the hours of clinical supervision shall be individual.)

☐	☐	If individual clinical supervision was received, it was face-to-face supervision with 1 or 2 supervisees and me, for a period no less than 1 hour of clinical supervision per session. ☐ Check here if no individual supervision was received.
☐	☐	If group clinical supervision was received, it was face-to-face supervision, between groups of supervisees (no more than 12 supervisees per group) and me, for a period no less than 2 hours of clinical supervision per session. ☐ Check here if no group supervision was received.
☐	☐	The supervisee and I are maintaining a clinical supervision log of hours that includes the date; start and stop times; the modality of supervision provided; and notes on recommendations or interventions used during the supervision.
☐	☐	There are ethical and/or legal concerns regarding the supervisee that I believe the Board should be made aware of. If yes, please explain and cite the NC Statutes or ACA ethical codes that you feel have been violated. Please attach additional sheets if necessary.

_____

_____

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I verify that the above information is accurate. I am available for consultation with the Board or its committees regarding the supervisee's competence.

For electronic report submissions (ONLY): I understand that typing my first and last name on the signature line below will be considered to be my electronic signature that has the same legal effect and can be enforced in the same way as my written signature.

Supervisor's Signature: _____ Date: _____

A Final Supervision Report form must be submitted to the Board within two (2) weeks of termination of supervision and within two (2) weeks of a change in the conditions specified in the supervision contract from on file with the Board.