



South Carolina Department of Labor, Licensing and Regulation
**South Carolina Board of Examiners for Licensure of
 Professional Counselors, Marriage and Family
 Therapists, Addiction Counselors
 and Psycho-Educational Specialists**

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llr.sc.gov/cou

**LAC CONFIRMATION OF
 CLINICAL SUPERVISION OF POST-MASTER'S CLIENT CONTACT**

Applicant/Associate Name: _____
 (As shown on license)

Associate License Number: _____

Licensed Supervisor/Mental Health Practitioner or Supervisor Candidate Verification Information

(To be completed by supervisor/mental health practitioner)

Check appropriate category: Supervisor Supervisor Candidate Mental Health Practitioner

License Type: _____ License No.: _____

Supervisor/Supervisor Candidate/Mental Health Practitioner Name: _____
 (As shown on license)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone No.: _____ Email: _____

Supervisor /Mental Health Practitioner Name: _____
 (If supervision is to be completed by a supervisor candidate, indicate the candidate's supervisor)

License Type: _____ License No.: _____

I verify that the applicant was under my supervision, at which time I critiqued the applicant's addiction counseling and addiction counseling-related skills based on one or more of the following forms of observation of the supervisee's addiction counseling practice: (Check all that apply)

Direct/Live Observation Live Supervision Audio Recordings

Written Clinical Materials Video Recordings Co-Therapy

APPLICANT'S EMPLOYMENT

Name, address, telephone and type of work experience (minimum of two years' experience)	Total Years	From (MM/YY)	To (MM/YY)

1. Confirmation of Supervised Clinical Experience of Direct Counseling Client Contact
(Must reflect a minimum of 1,000 hours of supervised clinical experience.)

Confirmation of 1,000 hours of direct client contact in addiction counseling of clients presenting with addiction issues under the supervision of a licensed addiction counselor supervisor, supervisor candidate, or other qualified licensed mental health practitioner.	Total Hours	From (MM/YY)	To (MM/YY)

2. Confirmation of 120 Hours of Post-Master's Documented Supervision

Confirmation of hours of supervision by a licensed addiction counselor supervisor or supervisor candidate (attach the supervision log)

	Total Hours	From (MM/YY)	To (MM/YY)
A. Individual/triadic (a minimum of 60 hours required to be individual supervision)			
B. Group			

RECOMMENDATION

I recommend / I do not recommend this applicant for licensure as a South Carolina licensed addiction counselor. **Note:** If you do not recommend this applicant/Associate, the board requests that you send a separate letter directly to the board office stating your reasons.

Additional comments:

ATTESTATION

I attest that all information provided herein concerning supervision and work experience is accurate to the best of my knowledge and is in keeping with the Professional Counselors, Marriage and Family Therapists, Addiction Counselors, and Psycho-Educational Specialist Practice Act. I understand that supervision for licensed associates and the duration for associate licensure are for a period of not less than two years.

Signature of Supervisor/Mental Health Prac: _____ Date: _____

Signature of Supervisor Candidate: (If applicable) _____ Date: _____