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
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4658 • Contact.Counselor@llr.sc.gov • Fax: 803-896-4719
llr.sc.gov/cou

LPC 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 <u>supervisor/mental health practitioner</u>)

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 counseling and counseling-related skills based on one or more of the following forms of observation of the supervisee's 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 1,380 hours of supervised clinical experience.)

Confirmation of 1,380 hours of direct client contact in counseling of under the supervision of a licensed professional counselor supervisor, supervisor candidate, or other qualified licensed mental health practitioner, that included experience assessing and treating clients with the more serious problems as categorized in standard diagnostic nomenclature.	Total Hours	From (MM/YY)	To (MM/YY)

2. **Confirmation of 120 Hours of Post-Master's Immediate Supervision**
   Confirmation of hours of supervision by a licensed professional counselor supervisor or supervisor candidate (attach the supervision log)

	Total Hours	From (MM/YY)	To (MM/YY)
A. Individual (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 professional 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: ____________