

**PLAN OF SUPERVISION FOR CANDIDATE OF LICENSED ADDICTION COUNSELOR
SUPERVISOR LICENSURE**

Candidate's Name _____

Preferred Address _____

Daytime Telephone Number () _____

SC LAC License Number _____ Expires _____

LICENSED SUPERVISOR INFORMATION

Supervisor's Name _____

Professional Mailing Address: Agency or Institution _____

Street/P O Box _____

City, State, Zip _____

Professional Telephone Number () _____

S.C. LAC License Number _____ Expires _____

S.C. LAC Supervisor License Number _____ Expires _____

I plan to supervise the addiction counseling supervision of the above named candidate over a period of time to begin _____(mo/year) and will end on approximately _____(mo/year). During this period, we have agreed to meet _____ times per week for approximately _____ hours per meeting. I understand that, according to Board Regulations and policy, at least **36** contact hours must be individual supervision of the candidate's supervision of at least two LAC-Interns (i.e., not more than two supervisors present during the supervisory sessions). At the completion of my supervision of this Candidate, I will confirm completion of the supervision requirements by a log of hours and by letter from me and will provide a recommendation regarding his/her appropriateness for supervisory licensure.

Signature of Supervisor

Date

CANDIDATE'S AFFIRMATION

"I HEREBY ATTEST TO THE FACT THAT ALL INFORMATION PROVIDED BY ME AND OTHERS IN THIS APPLICATION IS TRUE."

Signature of Candidate

Date