



**PROTECTIVE
HEALTH
SERVICES**

Oklahoma State Department of Health
Protective Health Services
Professional Counselor Licensing
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6030
FAX: (405) 271-1918
www.health.ok.gov/program/lpc

SUPERVISION AGREEMENT

Please check appropriate license: LPC LBP

Subchapter 310:405-11-5(a) of the LPC Regulations and Subchapter 310:403-15-5(a) of the LBP Regulations require that, "Three (3) years or three thousand (3000) clock hours of full time, on-the-job experience..." shall be completed.

The Regulations established by the Board, in addition to the 3000 hours of work are:

- 1) an approved supervisor
- 2) a minimum of a 20 hour work-week
- 3) weekly supervision sessions of 45 minutes in length for each 20 hours worked
- 4) 350 hours of direct face-to-face client contact for each 1000 hours worked
- 5) completion of the supervised experience within 60 months of the submission of this agreement
- 6) evaluations of supervised experience are to be submitted on a semi-annual schedule
- 7) approved supervisors shall perform at least two (2) observations (live or tape) per each six (6) month evaluation period for each supervisee.
- 8) approved supervisors shall consult with on-site supervisor at least once during each six (6) month evaluation period for each supervisee.

This supervision agreement must be completed, submitted, along with the Candidate Statement of Professional Disclosure form and the On-Site Supervisor Verification form to the Professional Counselor Licensing office, and approved by the Department before the candidate can begin to accrue supervision hours.

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LPC Regulations or Subchapter 15 of the LBP Regulations. I understand that a violation of those requirements can result in a loss of supervision hours and/or disciplinary action against both the candidate and the supervisor.

CANDIDATE

SUPERVISOR

Print name: _____

Place of Employment: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Date: _____

Signatures: _____

THIS FORM WILL NOT BE APPROVED IF NOT ACCOMPANIED BY THE CANDIDATE'S STATEMENT OF PROFESSIONAL DISCLOSURE AND THE ON-SITE SUPERVISOR VERIFICATION FORM

-----**(For office use only)**-----

Date approved: _____ PCL Staff approving: _____

Date disapproved: _____ Reason for disapproval: _____



Creating
a State
of Health

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STATEMENT OF PROFESSIONAL DISCLOSURE

CANDIDATE

Please check the appropriate license:

LPC

LBP

I am required by regulation to furnish this document to you. It requires that I inform you of my professional training, orientation/techniques, fees and credentials. I am working toward licensure as a Professional Counselor or Behavioral Practitioner (check the appropriate license above) under the auspices of the Oklahoma State Department of Health. I am in the process of accruing 3000 hours of supervised experience, which are required for licensure. Until that time, the supervising licensee listed below shall supervise me. My supervisor will be the contact person for you to obtain your records in the event of my infirmity or death.

I will be happy to discuss this information with you and/or furnish you with printed material concerning the licensing process. You may contact (without giving your name), the Professional Counselor Licensing Division listed on the masthead of this document. The Professional Counselor Licensing website is www.health.ok.gov/program/lpc.

SUPERVISOR

CANDIDATE

Name: _____

Address: _____

Phone: _____

Date: _____

Signature: _____

The above-designated Licensee Candidate has satisfactorily supplied me with information and/or printed material regarding his/her practice, licensure and professional development.

Signature of Client: _____ Date _____

