

SUPERVISED PRACTICE DOCUMENTATION (POST MASTERS)

FOR

ARKANSAS BOARD OF EXAMINERS IN COUNSELING

Must be professional work completed after the transcript date the Masters Degree was conferred.

Applicant: _____ SSN: _____

Supervisor: _____ Length of Supervision: _____

Dates from _____ to _____

Individual CCH worked per week: _____ SH per week: _____

Indirect CCH worked per week: _____ SH per week: _____

Group Hours worked per week: _____ SH per week: _____

Total Client Contact Hours: _____ Total Supervised Hours: _____

Work Setting and Title during Documented Supervised Practice:

Supervisor: _____

Applicant: _____

Describe the Categories of Counseling Contacts: _____

I VERIFY THE INFORMATION ABOVE AS ACCURATE FOR THE APPLICANT

Supervisor's Signature: _____ Date: _____

Print Supervisor's name: _____ Title: _____

Supervisor's Phone # _____ Institution: _____

Supervisor's address: _____

Do you (Supervisor) hold a license or certificate to practice as one of the following?

• Counselor • Therapist • Psychologist • Other: _____

License or Certificate Number: _____ Expiration Date: _____

**Return this form directly to: *Arkansas Board of Examiners in Counseling*
P.O. Box 70
*Magnolia, AR 71754-0070***