Clinical Supervision Documentation

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Name of Certification Applicant

To the Clinical Supervisor:

In the following spaces, please indicate the day and time of each face to face supervision session together with the type of supervision that you provided. Please print your name and provide your signature, indicating that you personally conducted the session on the given date and time. This form documents clinical supervision only. 200 clinical supervision hours are required.

DATE OF SUPERVISION	TIME (HOURS:MIN)	TYPE OF SUPERVISION (INDIVIDUAL, GROUP, ETC.)	SUPERVISION CONDUCTED BY (SIGNATURE ON EACH EVENT)
		Total Hours of Clinical Supervision Documented:	

Name of Supervisor: License/ Certification: Issued by Number:

Agency: Address: City, State, Zip:

Telephone: E-Mail:

I affirm that the performance demonstrated by this applicant is consistent with the standards of certification for counselors by the SCAADAC

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Signature of Clinical Supervisor