STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 WEST ADAMS STREET, SUITE 3600
PHOENIX, AZ 85007
PHONE: 602.542.1882 FAX: 602.364.0890
Board Website: www.azbbhe.us
Email Address: information@azbbhe.us

KATIE HOBBS
Governor

TOBI ZAVALA
Executive Director

COUNSELING
VERIFICATION OF CLINICAL SUPERVISION FORM

HOW TO SUBMIT		
EMAIL **applications@azbbhe.us** Emailed forms must only come from the Clinical Supervisor.	**OR**	**SEALED ENVELOPE** Clinical Supervisor's signature MUST be on the seal.

- **Form must be completed by Clinical Supervisor.**

- **IMPORTANT**: Clinical Supervisors must submit documents demonstrating ompliance with the Board's Clinical Supervisor education requirements. Have you previously submitted your training documents to the Board for review OR are you included on the Board's Clinical Supervisor Registry ☐ Yes ☐ No
  If no, you must attach documents demonstrating compliance.

R4-6-101 (A) (11)

"Clinical Supervision" means direction or oversight provided face to face or by videoconference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to engage in the practice of behavioral health ethically, safely, and competently.

A	**SUPERVISEE INFORMATION**		
Legal Name (First Name Last Name)			
Current AZ Board License(s) #	Issue Date(s)	Expiration Date(s)	
Email Address		Preferred Phone	
Supervisee's Title During Supervision	Title of Agency/Practice Where Supervised Work Was Performed		
Address	City	State	Zip Code

B	**CLINICAL SUPERVISOR INFORMATION**	
Legal Name (First Name Last Name)		
Current AZ Board License(s) #	Title	Preferred Phone
Email Address	During Supervision I Was: ☐ Employed by the same agency/practice ☐ Hired as an outside Clinical Supervisor *	

** **NOTE**: Applicants using a Clinical Supervisor who was not employed by the agency/practice where the supervision occurred must also submit the Clinical Supervisor Exemption Request Form if not previously submitted and approved. This does not apply to Clinical Supervisors who were approved by the Board to provide Supervised Private Practice.*

During the supervision period, did you have an active license with the AZ Board of Behavioral Health Examiners?

☐ YES ☐ NO

If NO, a credential verification must be attached from the regulating entity including: professional's name, credential title and number, issue and expiration dates, credential status, and past disciplinary actions.

C REPORT OF CLINICAL SUPERVISION HOURS

REPORTING PERIOD: *(Do NOT use "current" or "present")*

_____ to _____

Start Date (mm/dd/yyyy) *End Date (mm/dd/yyyy)*

Did you provide qualifying clinical supervision throughout the entire time period being verified above? ☐ YES ☐ NO

Please list the months that you did not provide qualifying clinical supervision and give an explanation below:

D CLINICAL SUPERVISION HOURS

1. Total hours of **individual supervision** provided:	
2. Total hours of **group supervision of 2 supervisees** provided:	
3. Total hours of **group supervision of 3-6 supervisees** provided	
4. Total hours of **direct observation of supervisee providing treatment** *Direct observation hours cannot be counted in individual or group supervision hours (lines 1-3). Total should only reflect time the clinical supervisor observed in a face-to-face setting, video/teleconference, or audio/video recording.*	
TOTAL HOURS OF **CLINICAL SUPERVISION** *(Sum of lines 1-4)*	

E OVERALL RATING

Please consider the supervisee's skills in individual/group psychotherapy, psychoeducation, assessment, diagnosis, and ethical conduct when determining your selection below **(must choose one):**

☐ **Below satisfactory** ☐ **Satisfactory** ☐ **Above Satisfactory**

Explanation of above rating (optional):

F SUPERVISOR ATTESTATION

I, _____ (Clinical Supervisor) certify that:

- _____ (Supervisee) was engaged in the supervised practice of counseling (including assessment, diagnosis and treatment) that met the Board's requirements as reported above.
- I have complied with the Board's Clinical Supervisor educational requirements and have remained in compliance for the reporting period above.
  - *Clinical Supervisors who are not included on the Board's registry must submit documentation demonstrating compliance*
- I have read and understand the clinical supervision requirements in A.A.C. R4-6-211 and R4-6-212 and certify that the clinical supervision identified above complied with those requirements.
- I have maintained clinical supervision documentation in compliance with the Board's rules and that I agree to provide such documentation upon request.
- All information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board not accepting the clinical supervision hours I provided the applicant and/or denying the applicant's licensure application.

_____ _____

Signature of Supervisor Date