Commonwealth of Virginia
Board of Counseling

Licensure by Examination – Step Two

**FORM LSATP 2-VS**

Photocopy This Form As Needed

# VERIFICATION OF SUPERVISION

## Post-Graduate Degree Supervised Experience

This form is to be **filled out by the supervisor** when the resident's supervision is completed. Include this form with your application in a separate, sealed envelope with the supervisor's signature across the seal. Complete all sections in Part One and **have your supervisor complete Part Two.** Quarterly Evaluations must accompany your LSATP application (unless you are applying by endorsement).

## PART ONE – TO BE COMPLETED BY THE APPLICANT

**Applicant's Name (Last, First, Middle)**

**Supervisor's Name (Last, First, Middle)**

**Supervisor's License Number** **License Type**

**Date License Issued** **Date of Expiration** **Issued in State of:**

## PART TWO – TO BE COMPLETED BY THE SUPERVISOR

*After completing return to resident in a sealed envelope with your signature across the flap.*

Supervision was given to resident from (mm/dd/yy) through (mm/dd/yy)

**DESCRIPTION OF SUBSTANCE ABUSE TREATMENT SERVICES RENDERED BY RESIDENT UNDER YOUR SUPERVISION**

1. Location where the supervision took place:

2. In your opinion, has the applicant demonstrated competency in substance abuse treatment sufficient for licensing and engaging in the independent practice of substance abuse treatment? YES NO
   Please elaborate:

| Both Columns Must Be Completed | Hours/Wk | Total Hrs |
|---|---|---|
| How many hours of **experience** did the resident obtain under your supervision? | | |
| How many hours of **direct client contact** did the resident obtain under your supervision? | | |
| How many hours of **individual supervision** did you provide the resident? | | |
| How many hours of **group supervision** did you provide the resident? | | |

# VERIFICATION OF SUPERVISION – CONTINUED

Your evaluation of the resident's competencies and the areas covered in supervision is required. These areas are outlined in Section 18 VAC115-60-80 of the Regulations. To complete supervision requirements the resident must have satisfied all items listed below in one or more supervisory experiences during 4,000 hours of counseling experience. Please place an "X" in the column that represents your evaluation of competencies.

**YES** = The applicant has satisfactorily demonstrated competencies in this area **NO** = Additional work is required to achieve competency **DNI** = Supervision did not include this area

| SUBSTANCE ABUSE TREATMENT COMPETENCIES | YES | NO | DNI |
|---|---|---|---|
| Clinical Evaluation | | | |
| Treatment planning, documentation and implementation | | | |
| Referral and service coordination | | | |
| Individual counseling | | | |
| Group counseling | | | |
| Client education | | | |
| Family education | | | |
| Community Education | | | |
| **CASE MANAGEMENT & RECORD KEEPING** | **YES** | **NO** | **DNI** |
| Maintains appropriate clinical records and client data. | | | |
| Understands circumstances under which various records can be released. | | | |
| **PROFESSIONAL IDENTITY & FUNCTION** | **YES** | **NO** | **DNI** |
| Uses supervision and shows continuing development of counseling skills. | | | |
| Demonstrates knowledge of strengths and limitations of an LSATP and the distinctive contributions of other mental health and health professionals. | | | |
| Makes appropriate referrals to other health providers and resources in the community. | | | |
| Handles appropriately, or knows how to handle, psychiatric emergencies. | | | |
| **PROFESSIONAL ETHICS & STANDARDS OF PRACTICE** | **YES** | **NO** | **DNI** |
| Understands and has discussed ethical issue concerning dual relationships. | | | |
| Knows the laws related to a counselor's duty in life-threatening situations, child & physical abuse, etc. | | | |
| Understands and has discussed the ethics of confidentiality and other legal and ethical issues. | | | |

**THIS EVALUATION HAS BEEN DISCUSSED WITH THE RESIDENT AND A COPY HAS BEEN PROVIDED TO THE RESIDENT.**

Signature of Supervisor: _____ Date: _____