



Commonwealth  
of Virginia  
Board of Counseling

# LSATP

Licensed Substance  
Abuse Treatment  
Provider

Please print & complete  
all sections.

Registration forms  
lacking a Social Security  
or VA Dept. of Motor  
Vehicles number will not  
be processed. This  
number will be used for  
identification and will not  
be disclosed for other  
purposes except as  
provided by law.

**ORIGINAL  
SIGNATURES ARE  
REQUIRED ON THE  
NEXT PAGE OF THIS  
FORM.**

**MAIL FORM,  
TRANSCRIPT AND FEE  
TO:  
BOARD OF  
COUNSELING  
9960 Mayland Drive  
Suite 300  
RICHMOND, VA  
23233**

## REGISTRATION OF SUPERVISION - LSATP FORM 1

Post Graduate Degree Supervised Experience

*Supervised work experience occurring in Virginia in any setting must be registered and approved by the Board prior to beginning that supervision.*

### Official Graduate Transcripts Must Be Submitted With This Form

\_\_\_\_\_ Initial Registration \$50    \_\_\_\_\_ Add A Supervisor \$25    \_\_\_\_\_ Change a Supervisor \$25

### TRAINEE INFORMATION:

First Name/Middle Initial

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Last Name

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Other Names (maiden name/other names used in transcripts and records)

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Street Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City

State

Zip Code

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Home Phone

Fax

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Business Phone

Extension

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E-Mail

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Social Security Number (or VA Dept. of Motor Vehicles No.)

Date of Birth

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Education/Training (List in chronological order all graduate schools attended. Include transcripts.)

Degree Earned	Date Degree Received	Major	Attendance Dates-mm/yr	Institution Name/State	Institution Code

**REGISTRATION OF SUPERVISION – PAGE 2**

**SUPERVISOR INFORMATION: (Supervisor must submit a current resume)**

First Name / Middle Initial / Last Name																			
Title																			
Business Name																			
Business Street Address																			
Business City / State / Zip Code																			
Business Phone								Ext.				Fax							
Email														Date of Birth					
License Number								Initial Licensure Date								Expiration Date			
State in which license was issued. Form 1-LV needed if not Virginia																			

**DOCUMENTATION OF PROFESSIONAL TRAINING IN SUPERVISION**

All supervisors shall document two years post-licensure substance abuse treatment experience, 100 hours of didactic instruction in substance abuse treatment, and training or experience in supervision. Within three years of January 19, 2000, supervisors must document a three credit hour graduate level course in supervision or a 4.0 quarter hours graduate level course in supervision, or at least 20 hours of continuing education in supervision, offered by a provider approved under 18VAC115-60-116, and hold an active, unrestricted license as set forth in 18VAC-115-60-80-D-1.

ATTESTATION: I, \_\_\_\_\_ declare under penalty of perjury under the laws of the Commonwealth of Virginia that I meet the above requirements.

**SIGNATURE OF SUPERVISOR:** \_\_\_\_\_

**SUPERVISION CONTRACT CONTINUED:**

**SUPERVISION CONTRACT - (Supervision to be provided to resident):**

Indicate number of hours per week: supervision  
\_\_\_\_\_ Individual supervision hours **per week**  
\_\_\_\_\_ Group supervision hours **per week**  
\_\_\_\_\_ Total work experience hours **per week**

**Supervision agreement must include a minimum of 1 hour, or a maximum of four 4 hours, for every 40 hours worked.**

Clinical Setting where experience is to be obtained: \_\_\_\_\_

**PLEASE PROVIDE "DETAILED INFORMATION OF THE SUPERVISION TO BE GIVEN" BELOW:**

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**SERVICES TO BE RENDERED BY THE TRAINEE WHILE IN SUPERVISION: (Include population(s) of clients to receive services, assessments to be used, and counseling techniques to be used.**

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I, \_\_\_\_\_, declare under penalty of perjury under the laws of the Commonwealth of Virginia that I have at least two years of post-licensure experience and have professional training in supervision, and that I will not provide supervision to \_\_\_\_\_ in areas outside of the competencies of my license to practice as a \_\_\_\_\_. As supervisor I assume responsibility for the clinical activities of the individual registered under my supervision. We hereby agree to this supervision contract which is being registered with the Virginia Board of Counseling.

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Resident: \_\_\_\_\_ Date: \_\_\_\_\_