

CLINICAL SUPERVISOR ASSOCIATION FORM

Use this form to notify DOPL of your intent to obtain clinical supervision hours.
A Supervisor must be approved by the Division BEFORE you begin accruing hours, NO EXCEPTIONS.
Hours may **NOT** be obtained before your AMFT, ACMHC, AMAC, or CSW license is active.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____
First Middle Last

Email: _____
Note: REQUIRED All Division notices and communication regarding supervision will be sent to this email.

Associate or CSW License Number: _____ Date Issued: _____

I understand and acknowledge that I am unable to count **ANY** supervision hours obtained toward full licensure before this form is on file with the Division. I further acknowledge and understand that there is no exception that will be made if this form is not on file. Furthermore, I understand and will abide by the requirements outlined in Utah Admin Code Subsection R156-60-308.1.

Signature of Applicant: _____ Date: _____

CLINICAL SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

Supervisor Name: _____
First Middle Last

Email: _____
Note: REQUIRED All Division notices and communication regarding supervision will be sent to this email.

License Type: _____ License Number: _____ State of Issue: _____

NOTE: If the supervisor listed above is licensed outside of the state of Utah an official verification of the supervisor's license, showing it is active and in good standing, must be submitted with this form.

I acknowledge that I have entered into a supervision contract with the individual named above and understand that by doing so I am committing myself to providing clinical supervision which includes direct client care as defined in Utah Code 58-60. Furthermore, I understand and will abide by the requirements outlined in Utah Admin Code Subsections R156-60-305.1, R156-60-306.1, R156-60-307.1.

Date Supervision Contract Signed: _____ Is This Supervision Full or Part Time: F P

During the clinical supervision required to obtain licensure for this individual, I approve the following mental health licensed individuals to participate in Direct Observation:

Approved Licensed Observers Name: _____
First Middle Last

License Number: _____ License Type: _____

Approved Licensed Observers Name: _____
First Middle Last

License Number: _____ License Type: _____

Signature of Supervisor: _____ Date: _____