

KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS

P.O. Box 1360
Frankfort, Kentucky 40602
<http://lpc.ky.gov>

LPCA SUPERVISION AGREEMENT

This application must be submitted with the appropriate signatures to the Kentucky Board of Licensed Professional Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by hand delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.

**SECTION 1
APPLICANT INFORMATION**

First Name Middle Name Last Name
() - () - () -
Home Telephone Work Telephone Fax Number

Street Address

Email Address

City State Zip Code

**SECTION 2
SUPERVISOR INFORMATION**

First Name Middle Name Last Name

Street Address

Email Address

City State Zip Code

() -
Telephone Number License Type License Number

Date of issue (attach a copy) Expiration Date (Attach a copy)

Do you hold a designation as a
licensed professional clinical
counselor supervisor Yes No

Current Number of LPCA Supervisees

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SECTION 3
INFORMATION RELATED TO SUPERVISED EXPERIENCE

Position title _____

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

Street Address

City

State

Zip Code

Average number of hours expected to be gained per week:

- Type of Setting:
- | | |
|--|---|
| <input type="checkbox"/> Government Agency | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Non-Profit | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> School | <input type="checkbox"/> Volunteer |
- Describe School Setting _____

Type of counseling experience to be gained (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Career & Vocational |
| <input type="checkbox"/> Child & Adolescent | <input type="checkbox"/> Drug & Alcohol |
| <input type="checkbox"/> General | <input type="checkbox"/> Group |
| <input type="checkbox"/> Marriage and Family | |
| <input type="checkbox"/> Other | |
- Describe: _____

Describe specifically, and in detail, what experience will be obtained to meet the criteria for: Direct responsibility for a specific individual or group of clients; and broad exposure and opportunity for skill enhancement with a variety of developmental issues, dysfunctions, diagnoses, acuity levels and population groups. (201 KAR 36:060)

Describe specifically, and in detail, how supervision will focus on: (a) the appropriate diagnosis of a client problem leading to proficiency in applying professionally recognized clinical nomenclature; the development and modification of the treatment plan; the development of treatment skills suitable to each phase of the therapeutic process; ethical problems in the practice of professional counseling; and the development and use of the professional self in the therapeutic process.(201 KAR 36:060)

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I, the applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- I have read the Board's statutes and regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- I will meet with my supervisor approximately one hour each week with a minimum of three hours per month of documented supervised experience;
- I will abide by all rules of the board, including the ethics requirements;
- I understand the associate license is only valid while I practice under supervision;
- I will notify the board if this supervisory arrangement is terminated; and
- I understand any additional supervisors and settings shall be approved by the board in advance.

Signature of Applicant

Date

Printed Name

This agreement shall not be effective until the board has issued a letter of approval of this agreement.

I, the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- All supervised experience will be completed in accordance with the statutes and regulations related to supervised experience and all subsequent board rules.
- I will provide supervision to the above name applicant at least one hour during each week of documented experience.
- I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- I understand the supervisory arrangement is only valid while my license remains active.
- I will notify the board if the supervisory arrangement is terminated.
- I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for LPCC licensure at the same time.

Signature of Supervisor

Date

Printed Name

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THE APPLICANT AND SUPERVISOR MUST KEEP A COPY OF THIS FORM FOR RECORDS.

A FEE MAY BE APPLICABLE IF COPIES ARE REQUESTED FROM THE BOARD.