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STATE OF DELAWARE

**BOARD OF MENTAL HEALTH AND CHEMICAL
DEPENDENCY PROFESSIONALS**

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PLANNED DIRECT SUPERVISION

INSTRUCTIONS – Upload this document when you submit your application or Service Request to *Manage Affiliations*

The proposed clinical supervisor completes this PLANNED DIRECT SUPERVISION form to document hours that he or she will be directly supervising a LAMFT. The following supervision information applies:

The planned hours entered in the **Written Plan** must total at least the mandatory minimum 1,600 hours of direct supervision.

- The planned hours of couple and family therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of individual therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of combined couple and family therapy or individual therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of face-to-face supervision entered in the **Written Plan** must total at least 100 hours.

All required hours—completed plus planned whether or not directly supervised—must span a period of not less than two but no more than four years

Applicant Name: _____
Last First Middle

INFORMATION ABOUT PROPOSED MFT SUPERVISOR - To be completed by *Clinical Supervisor* only

1. Supervisor Name: _____
Last First Middle

2. Check all that apply to you:

- I am an American Association for Marriage and Family Therapy approved supervisor.
- I am an American Association for Marriage and Family Therapy approved supervisor in training.
- I was approved by the Delaware Board to supervise. Enter approval date: _____
- Other: _____

3. Provide the following information about your professional

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
<input type="checkbox"/>	Marriage and Family Therapist			
<input type="checkbox"/>	Clinical Social Worker			
<input type="checkbox"/>	Clinical Psychologist			
<input type="checkbox"/>	Professional Counselor of Mental Health			
<input type="checkbox"/>	Psychiatrist trained in marriage and family therapy			

If you are a marriage and family therapist *not* licensed in Delaware, the Board requires proof that you have passed the AMFTRB exam and have five years' experience as a marriage and family therapist

4. Are you a Delaware-licensed LMFT? Yes No If yes, enter your license number: FT - _____
If no, describe your supervisory experience and credentials:

5. Supervisor's Practice Name (if applicable): _____

6. Practice Address: _____

City State Zip

7. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

8. Enter the dates of planned post-Master’s clinical experience that the applicant will provide under your direct supervision: From _____ To _____
 Month/Year Month/Year

This period must not span more than four years.

9. During the period entered above, how many total hours of **marriage and family therapy** that the applicant will provide under your **direct professional supervision**: _____

10. Show how the total hours you entered in Question 9 will break out into the following categories:

Answers such as “40 hours/week” will not be accepted.

- Couple and family therapy hours: _____
- Hours of face-to-face supervision: _____
- Hours of individual therapy: _____
- Combined couple and family therapy or individual therapy: _____

11. I attest that I have discussed the following with the applicant before completing this form. Answer each question. **If you answer ‘NO’ or ‘N/A’ to any question, enclose a written statement explaining why.**

I have explained to the applicant that I have the training, credentials, and competence to provide supervision in Delaware.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have discussed my role and responsibilities with the applicant. These include: <ul style="list-style-type: none"> • Evaluating the applicant’s clinical competence and preparedness to practice independently • Ensuring that the applicant practices within the professional and ethical standards of the field • Ensuring that the applicant is aware of the rules and regulations for practicing independently in Delaware 	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have discussed a contingency plan for dealing with emergencies and crises.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained my model and style of supervision to the applicant.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have reviewed the supervisory feedback process, including performance appraisal, evaluation feedback, documentation, and feedback intervals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained how I will assess the applicant’s comprehension of ethical, legal, and professional requirements.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have ensured that the appropriate liability coverage is in place for the applicant and for myself.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have developed a process to address any issues or concerns regarding the applicant’s performance, including the utilization of a third-party to remediate any performance issues, consultation for additional assistance, or options to address concerns.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained my role in endorsing the applicant for licensure or employment based on the applicant’s demonstrated competence and qualifications and that I will not endorse an applicant whom I believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained to the applicant that I have the training, credentials, and competence to provide supervision to a LACMH/LAMFT pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained how I will assess the applicant’s comprehension of ethical, legal, and professional requirements pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have the ethical and legal authority to access confidential client information of the LACMH/LAMFT. Note: For supervisors who are not employees of the clinical setting where LAMHC/LAMFT is seeing clients a written agreement between the supervisor and agency should be executed.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ **Date:** _____