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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

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
☐	Marriage and Family Therapist			
☐	Clinical Social Worker			
☐	Clinical Psychologist			
☐	Professional Counselor of Mental Health			
☐	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 categorie

Answers such as "40 hours/week" will <u>not</u> 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 ☐ No ☐ N/A ☐
I have discussed my role and responsibilities with the applicant. These include: • 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 ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐
I have discussed a contingency plan for dealing with emergencies and crises.	Yes ☐ No ☐ N/A ☐
I have explained my model and style of supervision to the applicant.	Yes ☐ No ☐ N/A ☐
I have reviewed the supervisory feedback process, including performance appraisal, evaluation feedback, documentation, and feedback intervals.	Yes ☐ No ☐ N/A ☐
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements.	Yes ☐ No ☐ N/A ☐
I have ensured that the appropriate liability coverage is in place for the applicant and for myself.	Yes ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐
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 ☐ No ☐ N/A ☐

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: _____**