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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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DIRECT SUPERVISION REFERENCE
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

This form is ***not*** required for applicants applying by reciprocity.

The purpose of this form is to verify the ***hours of post-Masters mental health counseling*** that an applicant has provided while under the ***direct supervision*** of an ***approved clinical*** or ***acceptable supervisor***.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical supervisor must complete the entire form (excluding the applicant name), sign it and mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

In completing this form, the following applies:

- Applicants ***must*** complete *at least* 3,200 hours of mental health counseling services over a period of ***at least two but not more than four*** **consecutive years**.
- Of the required 3,200 hours of total experience, *at least* 1,600 hours **must** be completed under the direct clinical supervision of an *approved* or *acceptable* supervisor.
  - An approved supervisor is a Licensed Professional Counselor of Mental Health
  - An acceptable supervisor **must** be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) ***with*** a specialty or expertise in a clinical competency essential to the applicant's training.
  - ***Certified school counselors and certified school psychologists are not approved clinical supervisors***.
- When totaled, *at least* 100 of the 1,600 hours of direct clinical supervision ***must*** be face-to-face sessions between the applicant and supervisor. *At least* 60 of the 100 hours must be face-to-face one-on-one – that is, applicant and supervisor. The remaining 40 may be in a group setting – that is, applicant, supervisor, and up to five other supervisees

Section 2.4 of the Board's Rules and Regulations explains the supervision requirements.

MAIL THIS DOCUMENT DIRECTLY TO THE BOARD OFFICE. ENTER YOUR APPLICATION ID:_____

1. Applicant Name: _____ _____ _____
   Last First Middle

INFORMATION ABOUT CLINICAL SUPERVISOR

2. Supervisor Name: _____ _____ _____
   Last First Middle

3. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			
☐	Other:_____			

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

5. Practice Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

7. Did you provide ***direct supervision,*** as defined above, to the applicant? Yes ☐ No ☐ If no, skip to the **Signature**.

8. Enter the dates of post-Master's clinical experience that the applicant provided while under your direct supervision:

   From _____ To _____
   Month/Year Month/Year

   This period must not span more than four years.

9. During this period, how many total hours of mental health counseling did the applicant provide while under your direct supervision? _____

   Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

10. During this period, how many total hours of face-to-face, individual (one-on-one) supervision did you provide to the applicant? _____

11. During this period, how many total hours of face-to-face, group supervision did you provide to the applicant? _____

CERTIFICATION

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

Clinical Supervisor Signature: _____ Date: _____