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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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REQUEST FOR ALTERNATIVE PROFESSIONAL SUPERVISOR

INSTRUCTIONS: Upload this document when you submit your application

The purpose of this form is to document your efforts to locate a supervisor within the profession for which you are seeking a license, including:

- Licensed Professional Counselor of Mental Health (LPCMH) or Licensed Associate Professional Counselor of Mental Health (LAPCMH),
- Licensed Marriage & Family Therapist (LMFT), or Licensed Associate Marriage & Family Therapist (LAMFT)
- Licensed Chemical Dependency Professional (LCDP).

Supervision by a professional outside of your field *may* be approved by the Board, if the applicant can establish that the supervision was provided by another licensed mental health professional with a specialty or expertise in a clinical competency area essential to the applicant's training. The applicant must provide the Board with a compelling clinical reason for utilizing a supervisor outside of the profession for which they are seeking licensure.

Applicants must provide documentation for completion of 3,200 hours of supervised mental health counseling acceptable to the Board, over a period of no less than 2 but no more than 4 consecutive years. Of the 3,200 hours, 1,600 must involve the provision of face-to-face professional mental health clinical counseling services and be completed under the professional direct supervision of an individual who meets the requirements of the profession for which you are seeking licensure. At least 100 hours of the 1,600 must be face-to-face professional direct supervision with the applicant's supervisor. Please see your professions License Law and Rules & Regulations for complete information.

1. Applicant Name: _____

2. Enter the following information about each agency you contacted. If you need more room, enclose a separate sheet.

AGENCY	DATE	RESULT

3. Enter the following information about each database or directory searched for a clinical supervisor. If you need more room, enclose a separate sheet.

DATABASE	DATE	PERSON CONTACTED

4. Enter the following information about all additional attempts and/or contacts, not covered in the questions above, that you have made to secure post-master's supervision from a professional licensed in your field:

CONTACT	DATE	RESULT

5. Explain in detail any additional steps you took to secure a supervisor and why you were unable to locate a supervisor from a professional licensed within your field:

   _____
   _____
   _____
   _____

6. Proposed Supervisor Name: _____

7. List any specific specializations or expertise of your proposed supervisor:

   _____
   _____

8. Please explain how this contributes to your clinical competency:

   _____
   _____
   _____
   _____

Please upload the resume or CV of the supervisor you are requesting

AFFIDAVIT

I certify that the information provided in this statement is accurate and complete to the best of my knowledge and belief. I understand that the Delaware Board of Mental Health and Chemical Dependency has the right to deny or revoke licensure, if I provide fraudulent information.

Signature of Applicant: _____ **Date**: _____