

To be completed and submitted directly to the Board by each Supervisor
sdbce@midwestsolutionsd.com

Attachment A – Supervised Experience with Board Approved Supervisor

The supervisee named below is applying for a license to practice counseling in the State of South Dakota. The South Dakota Board of Examiners for Counselors and Marriage and Family Therapists requires submission of information by the approved supervisor, to verify the candidate's supervised experience.

SUPERVISEE INFORMATION

Supervisee Name: _____ Practice Location: _____

Type of Plan of Supervision: ___LPC ___LPC-MH ___LMFT

SUPERVISOR INFORMATION

Name of Approved Supervisor: _____ License # _____

License type: ___LPC ___LPC-MH ___LMFT ___CSW-PIP ___Psychologist ___Psychiatrist

As required by South Dakota Law and Administrative Rules, I attest to the following statements:

I attest to the fact the above Supervisee completed the minimum hours of direct client contact.
Supervisor’s Initials _____

I attest to the fact the above Supervisee completed the minimum 100 hours of supervision.
Supervisor’s Initials _____

I attest that one hour of supervision took place for every 20 hours of direct client contact by the Supervisee. Supervisor’s Initials _____

I attest to the fact at least five hours of each of the required supervision methods took place during supervision. (Not applicable for LPC-MH Plan of Supervision) Supervisor’s Initials _____

- | | |
|---|--------------|
| 1. The presentation and staffing of cases; | Hours: _____ |
| 2. The critiquing of audio or video counseling; | Hours: _____ |
| 3. The direct observations of the supervisee; | Hours: _____ |
| 4. Co-counseling with the supervisee; and | Hours: _____ |
| 5. Review of supervisee recordkeeping. | Hours: _____ |

I attest I held an active license during the entirety of this supervision period. Supervisor’s Initials _____

Attachment A – Continued

Supervisee Name: _____

Type of Plan of Supervision: ___LPC ___LPC-MH ___LMFT

Tracking Form Summary

Dates of Supervision by this supervisor Start (mm/dd/yy)* _____

End (mm/dd/yy) _____

Direct Client Contact*

Number of Direct Client Contact hours acquired by electronic means: _____

Number of Direct Client Contact hours acquired in person: _____

Total number of Direct Client Contact hours supervised during this period: _____

Supervision Hours**

Total number of supervision hours acquired in individual setting: _____

Total number of supervision hours acquired in a group setting: _____

Total number of supervision hours: _____

“I attest to the fact these hours are true and accurate.” **Supervisor’s Initials** _____

*If supervisee is pursuing a professional counselor license (LPC) no more than 400 hours of direct client contact may be acquired by electronic means.

If supervisee is pursuing a marriage and family therapist license (LMFT) nor more than 1,000 hours of direct client contact may be acquired by electronic means.

If supervisee is pursuing a professional counselor-mental health license (LPC-MH) all direct client contact hours may be acquired by electronic means.

** No more than 50 hours of supervision may be acquired in a group setting.

I attest to the fact the information I have provided above is true and accurate; that I was responsible for this applicant’s supervision as documented on this Attachment A, supervision took place within the requirements of South Dakota laws and administrative rules and that we were compliant with the South Dakota laws and administrative rules.

Supervisor’s Signature

Date

Scan and send completed form to sdbce@midwestsolutionsd.com