SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES

SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS & MARRIAGE AND FAMILY THERAPISTS

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionssd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

APPLICATION FOR BOARD APPROVED SUPERVISOR

Please submit:

1. Completed application;
2. Proof of completion of four hours of qualified continuing education, focused on supervision, in the two years immediately preceding the submission of this application;
3. Verification of license; and
4. Quality color photograph of applicant.

There is no fee for an Approved Supervisor Application. If approved, the Supervisor Status is valid from the date of approval through November 30 of the next even-numbered year and is subject to renewal. Proof of at least four hours of qualified continuing education, focused on supervision, acquired during the current continuing education cycle is required with application.

APPLICANT INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

E-mail: _____ Phone: _____

Name of Business: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SUPERVISOR QUALIFICATIONS

Please select one:

☐ Licensed by the SD Board of Examiners for Counselors & Marriage and Family Therapists and credentialed as an Approved Clinical Supervisor by the Center for Credentialing & Education, Inc. and recognized by the NBCC;

☐ Licensed as a professional counselor, professional counselor-mental health, marriage and family therapist, certified social worker-private independent practice, psychologist or psychiatrist; actively licensed for at least two years; and 4 hours of qualified continuing education focused on supervision;

☐ Licensed as a professional counselor, professional counselor-mental health, marriage and family therapist, certified social worker-private independent practice, psychologist or psychiatrist; actively licensed for at least one year; and 15 hours of qualified continuing education focused on supervision; **or**

☐ Licensed by the Board and an American Association for Marriage and Family Therapy approved clinical supervisor.

LICENSE INFORMATION AND VERIFICATION

Please denote the current license(s) you hold and attach a copy of your current license(s):

License Type	License Number	Original Issue Date	Valid Through Date
LPC			
LPC-MH			
LMFT			
Psychologist			
Psychiatrist			
CSW-PIP			

TRAINING REQUIREMENTS

At least four hours of training in supervision is required, please list the training you have completed within the past two years.

Date	Type (Supervision)	Course Title	Course Sponsor	Course No.	Hours

LEGAL QUESTIONS (***If you answer yes to any question below, please provide a separate written explanation.)***

☐ YES ☐ NO Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

☐ YES ☐ NO Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

☐ YES ☐ NO Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

☐ YES ☐ NO Are you $1,000 or more behind in child support payments?

ACKNOWLEDGEMENT OF SUPERVISOR RESPONSIBILITIES

Acknowledge the following statements by marking the appropriate answer to each statement.

1) ☐ Yes ☐ No I agree to serve as a Board Approved Supervisor.

2) ☐ Yes ☐ No I acknowledge the Supervisor duties and requirements that I must follow, including the required four methods of supervision as outlined by South Dakota administrative rules.

3) ☐ Yes ☐ No I will follow the ACA/AAMFT Code of Ethics as a Supervisor.

4) ☐ Yes ☐ No I ensure the practice setting/location is appropriate for Supervisees.

5) ☐ Yes ☐ No I agree to notify the Board, in writing, of the completion or termination of an approved post graduate plan of supervision within **14 days** of the completion or termination of the plan.

By signing, I attest that I understand and acknowledge the requirements needed to supervise candidates and agree to follow all South Dakota laws and administrative rules for an Approved Supervisor.

Applicant Signature _____ Date _____

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Mail completed application and supporting documents to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Board Use Only:
Completed Application: Yes No *If no, missing:* _____
Date Received: _____
Date Approved: _____ *Renewal due:* _____