**FORM S-2**

# VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

Part of State Form 50319 (R10 / 8-22)

*Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have received at least one hundred (100) hours of face to face supervision while employed for no less than 21 months and no more than 48 months. **This form may be duplicated if your one hundred (100) hours of face to face supervision have been completed through multiple supervisors.** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** (on the reverse side of this form) for each previous supervisor. Sign the form(s) and return the form to the Professional Licensing Agency.*

## SECTION A / APPLICANT INFORMATION

| Name of applicant (*last, first, middle,maiden*) | Social Security number * | |
|---|---|---|
| Name of supervisor | Supervision begin date *(month, day, year)* | Supervision end date *(month, day, year)* |

## SECTION B / SUPERVISOR INFORMATION

*This section is to be completed by the applicant's previous or current supervisor and sent directly from the applicant's previous or current supervisor to the Professional Licensing Agency at the address listed on the bottom of this form.*

Total number of hours of face-to-face supervision you provided to the above-named applicant: _____

Total number of months above supervision was completed: _____

The above-named applicant was providing mental health counseling services directly to clients at the time of my supervision?

☐ Yes ☐ No ☐ If No, please explain: _____

The applicant's virtual supervision was no more than fifty percent (50%) of the total supervision: ☐ True ☐ False

| Printed name of supervisor | | |
|---|---|---|
| Cellular telephone number | Work telephone number | Email address |
| Signature of supervisor | Date *(month, day, year)* | |

**FORM S-2**

## VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) *(continued)*

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**SECTION C / AFFIRMATION OF SUPERVISION**

*To be completed by applicant if your previous supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why your previous supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

*Please indicate below the reason why your previous supervisor is no longer able to complete SECTION B.*

My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

*If you selected "Other reason", please briefly explain:*

Supervision was provided by: _____

Name of supervisor *(last, first, maiden)*

Total number of hours of face-to-face supervision you have received from this supervisor while providing mental health counseling services directly to clients: _____

Date of supervision: _____ to _____

*(month/year* *(month/year)*

*List all graduate degrees, credentials and / or state board issued licenses / certifications that qualified this individual to serve as a mental health counselor supervisor:* _____

**APPLICATION AFFIRMATION**

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

| Signature of applicant | Date (*month, day, year*) |
|---|---|
| | |