



For Official Use Only

Approved: Yes No
 Date: _____

New Jersey Office of the Attorney General
 Division of Consumer Affairs
 State Board of Marriage and Family Therapy Examiners
 Professional Counselor Examiners Committee
 124 Halsey Street, 6th Floor, P.O. Box 45044
 Newark, New Jersey 07101
 (973) 504-6582

Proposed Plan of Supervised Counseling Experience
 (This form should be completed by the supervisor and forwarded directly to the Committee.)

Please print clearly.

Name of applicant: _____

Last name
First name
Middle initial

Applicant's address: _____

Street or P.O. Box
City
State
ZIP code

Associate Counselor license number: _____

Supervisor's Information

Last name
First name
Middle initial
Other names if applicable

Business name: _____

Type of business (nonprofit, for profit, group, private, etc.)

Business address

City
State
ZIP code

Telephone number: _____ E-mail address: _____

(include area code)

- (1) **YOU [THE SUPERVISOR] MUST ATTACH YOUR CURRENT RESUME/CURRICULUM VITAE, A COPY OF THE SUPERVISORY CREDENTIAL, and**
- (2) **OFFICIAL JOB DESCRIPTION FOR THE ASSOCIATE COUNSELOR.**
- (3) **PURSUANT TO N.J.A.C. 13:34-13.1(c) THE WRITTEN SUPERVISION PLAN SHALL BE APPROVED BY THE COMMITTEE PRIOR TO THE PERFORMAMANCE OF COUNSELING BY THE ASSOCIATE COUNSELOR.**

Qualified supervisor: N.J.A.C. 13:34-10.2 and 13.1(a) (Check all that apply.)

ACS (NBCC-Issued) Three (3) graduate credits: Clinical Supervision Other: _____
 (Attach official verification for area(s) you checked.)

Licensure of supervisor: N.J.A.C. 13:34-10.2 and 13.1(a) (Check all that apply.)

Completed a minimum of 3 years' (4,500 hours) experience as licensed (checked below):

<input type="checkbox"/> Marriage and Family Therapist	<input type="checkbox"/> Professional Counselor	<input type="checkbox"/> Licensed Clinical Social Worker
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Rehabilitation Counselor

Other: _____

Type of license or certificate	Number	State or jurisdiction issuing license or certificate	Date of initial issue/expired

1. Have any of the supervisor's licenses ever been suspended, revoked or restricted? Yes No
 If "Yes," attach documentation and an explanation to this form.

2. Where will client contact and supervision take place?

Agency name
Address
Telephone number (include area code)

Agency tax status: For-profit Not-for-profit

3. Graduate school attended: _____

Major: _____ Highest degree earned: _____

4. Is there any circumstance that precludes your objective assessment of the applicant? Yes No
If "Yes," please explain on a separate sheet of paper. N.J.A.C. 13:34-13.1 (Examples: current and former clients, current employers (employees may not supervise employers), relatives of the supervisor, relatives of current clients, current students or close friends.)

5. N.J.A.C. 13:34-13.1(g)
Prior to the treatment of each client, supervisors are required to obtain a written disclosure that is: easily readable, clearly understood, signed by the client and retained in the client's record. The disclosure must also acknowledge notice that services are to be rendered by an associate counselor under the supervision of a qualified supervisor.

6. Does the proposed supervisor have any other individuals under clinical supervision? (See N.J.A.C. 13:34-3.1(f).) Yes No
If "Yes," provide the names of the other individuals and the total number of supervisees:

7. What is the proposed number of direct client contact hours you plan to meet WEEKLY? (See N.J.A.C. 13:34-10.2, "One Calendar Year" means a maximum of 1,500 hours/year, 125 hours/month, 30 hours/week.)
Couples _____ Families _____ Individuals _____ Groups _____

8. What is the proposed number of hours of supervision you plan to meet WEEKLY?
Individual or Dyad (two people) _____ Group _____
(N.J.A.C. 13:34-10.2 requires at least 50 hours of face-to-face supervision per one calendar year at the rate of one hour per week, of which not more than 10 hours may be group supervision.)

9. What are the inclusive dates with the above supervisor? Beginning: _____ Anticipated Ending: _____
month/day/year month/day/year

10. Type of supervisory modalities to be utilized: (See N.J.A.C. 13:34-13.1(b) and check all that apply. At least one must apply.)
Note the supervision requirements at N.J.A.C. 13:34-13.1(b), (c) and (d)1, 2 and 3.
 Audiotape Videotape Session observation/Live supervision

11. Do you agree to maintain weekly supervision notes which will be made available to the Committee upon request? Yes No

12. Describe the proposed client services you are contracting to provide, pursuant to N.J.A.C. 13:34-10.2 (**please include the applicant's detailed job description**). (Add separate pages as needed.)

13. Has the applicant read the statutes and regulations of New Jersey that govern the practice of professional counseling? Yes No
(N.J.S.A. 45:8B-34 et seq. and N.J.A.C. 13:34-10.1 through 31.8)

14. Has the supervisor read the pertinent statutes and regulations of New Jersey? Yes No
(N.J.S.A. 45:8B-34 et seq. and N.J.A.C. 13:34-10.1 through 31.8)

