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

For Official Use Only
Approved: ☐ Yes ☐ No
Date: _____

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 PERFORAMANCE 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: (Check all that apply.)
☐ Completed a minimum of 2 years' (3,000 hours) experience as licensed (checked below):
☐ Marriage and Family Therapist ☐ Professional Counselor ☐ Licensed Clinical Social Worker
☐ Psychologist ☐ Psychiatrist ☐ Rehabilitation Counselor
☐ Other: _____

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

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

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

_____
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: _____ (month/day/year) Anticipated Ending: _____ (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)

15. According to your understanding, what are the personal learning objectives of the supervisee?

_____

_____

_____

_____

_____

_____

16. To your knowledge, will the supervisee have more than one supervisor in the above or another setting during the inclusive dates?

☐ Yes ☐ No

If "Yes," please advise the supervisee to request that a separate form be submitted by that supervisor.

_____	_____	_____
Applicant's signature	Proposed supervisor's signature	Date

THE SUPERVISOR IS REQUIRED TO IMMEDIATELY NOTIFY THE PROFESSIONAL COUNSELOR EXAMINERS COMMITTEE OF ANY CHANGES IN THE EMPLOYMENT OF EITHER THE APPLICANT OR THE SUPERVISOR.

Certification

I certify that all of the foregoing information provided herein is true and if any information provided by me is willfully false, I am subject to punishment.

Supervisor's signature: _____ Date: _____

Please submit the following with the completed Plan:

1. Supervisor Resume
2. Copy of Supervisory credential
3. Associate Counselor's Official job description on agency/practice letterhead pursuant to N.J.A.C. 13:34-10.2