



STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
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DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

REQUEST FOR APPROVAL OF CLINICAL SUPERVISOR

Complete this form *ONLY* for master's level non-independent practitioners seeking to work under direct supervision in their own practice in which they have ownership interest or manage pursuant to A.A.C. R4-6-211(B). Supervisor will be responsible to monitor and oversee practice while providing direct and clinical supervision.

Initial Request

Change of Supervisor

PART I. SUPERVISEE INFORMATION			
<input type="checkbox"/> MRS. <input type="checkbox"/> MS. LEGAL NAME (FIRST NAME, MI, LAST NAME)			
<input type="checkbox"/> MR. <input type="checkbox"/> DR.			
CURRENT AZ BOARD LICENSE(S) #	ISSUE DATE(S)	EXPIRATION DATE(S)	
HOME ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	EMAIL ADDRESS

PART II. CLINICAL SUPERVISOR INFORMATION			
<input type="checkbox"/> MRS. <input type="checkbox"/> MS. LEGAL NAME (FIRST NAME, MI, LAST NAME)			
<input type="checkbox"/> MR. <input type="checkbox"/> DR.			
CURRENT AZ BOARD LICENSE(S) #	ISSUE DATE(S)	EXPIRATION DATE(S)	
HOME ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	EMAIL ADDRESS

PART III. PRACTICE SETTING			
PRACTICE NAME			
PRACTICE ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	EMAIL ADDRESS
DESCRIBE SCOPE OF PRACTICE AND SERVICES PROVIDED			PART TIME OR FULL TIME

Supervisee (*check one*) has ownership in manages the practice where direct/clinical supervision will occur.

PART IV. ATTESTATIONS

Both parties shall initial below indicating their acknowledgement and agreement of the following:

Supervisee's Initials	Supervisor's Initials	
		1. Attached is documentation demonstrating the proposed clinical supervisor is in compliance with the clinical supervisor educational requirements pursuant to A.A.C. R4-6-214 (<i>not required if supervisor is included on the Board's registry and currently in compliance</i>)
		2. Clinical supervisor is not prohibited from providing clinical supervision by a Board consent agreement, and will provide notice to supervisee should they become prohibited in the future.
		3. A copy of the required agreement between supervisor and supervisee is attached pursuant to A.A.C. R4-6-211(B)(2).
		4. If the supervisee seeks to use the supervised work experience and clinical supervision hours toward independent licensure in the future, the supervision must meet the clinical supervision requirements in A.A.C. R4-6-212, in addition to the requirements in A.A.C. R4-6-211.
		5. Misrepresentation by a supervisor, applicant or licensee may constitute unprofessional conduct.
		6. Proposed clinical supervisor has a minimum of two years of experience in the practice of behavioral health since acquiring independent licensure.
		7. Pursuant to A.A.C. R4-6-101(A)(11), "Clinical supervision" means direction or oversight provided either face to face or by video conference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to engage in the practice of behavioral health ethically, safely, and competently.
		8. Practice by a masters level non-independent licensee operating or managing their own entity with immediate responsibility for the behavioral health services provided by the licensee may not commence until receiving approval of the proposed supervisor and agreement between the supervisor and supervisee.
		9. Supervisor understands that they are to monitor the private practice as well as provide direct and clinical supervision to supervisees.

We, the undersigned supervisee and supervisor, acknowledge that we have both read and agree to the statements above, and have read and understand the direct and clinical supervision requirements set forth in the Board's regulations. We also certify under penalty of perjury that the above information and all supporting documents are true and accurate to the best of our knowledge.

Signature of Supervisee

Date

Signature of Supervisor

Date

AGENCY USE ONLY	APPROVED <input type="checkbox"/> Yes <input type="checkbox"/> No	APPROVAL DATE _____
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