STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 WEST ADAMS STREET, SUITE 3600
PHOENIX, AZ 85007
PHONE: 602.542.1882 FAX: 602.364.0890
Board Website: www.azbbhe.us
Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

SUPERVISED PRIVATE PRACTICE VERIFICATION OF CLINICAL SUPERVISION REPORT

HOW TO SUBMIT		
EMAIL spp@azbbhe.us	**FAX** (602) 364-0890	AZ Board of Behavioral Health Examiners 1740 W. Adams St, Suite 3600 Phoenix, AZ 85007

REPORTING PERIOD: _____ to _____
Start date *End date*

A SUPERVISEE/OWNER INFORMATION

Board rules require that licensees report any change in contact information within 30 days of the change.

LEGAL NAME (FIRST NAME, MI, LAST NAME)			
HOME ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	EMAIL ADDRESS

B CLINICAL SUPERVISOR INFORMATION

Board rules require that licensees report any change in contact information within 30 days of the change.

LEGAL NAME (FIRST NAME, MI, LAST NAME)			
HOME ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	EMAIL ADDRESS

C SUPERVISED PRIVATE 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

D SUPERVISED PRACTICE AND CLNICAL SUPERVISION HOURS

"Direct Client Contact" means performance of therapeutic or clinical functions related to the applicant's professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients. A.A.C. R4-6-101(23), A.R.S. § 32-3251

Total direct client contact hours:	

"Clinical Supervision" means direction or oversight provided face to face or by videoconference 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. A.A.C. R4-6-101(11)

Total individual supervision hours: Supervisor and supervisee must meet individually for 1 hour for every 20 hours of direct client contact. Include onsite clinical supervision hours.	
Total onsite clinical supervision hours: Supervisor and supervisee must meet onsite every 60 days.	

Dates of onsite supervision: _____

F SUPERVISOR ATTESTATION

I, _____ (Supervisor) certify that:

- _____ (Supervisee) was engaged in the supervised practice of behavioral health that met the Board's requirements as reported above.
- I meet the Board's educational requirements pursuant to A.A.C. R4-6-214.
- I have completed thorough and regular reviews of documentation.
- I have read and understand the clinical supervision requirements in A.A.C. R4-6-211 and that the clinical supervision identified above complied with those requirements.
- I have maintained clinical supervision documentation in compliance with the Board's rules and that I agree to provide such documentation upon request.
- I am not be prohibited from providing clinical supervision by a Board consent agreement.
- I understand that if supervisee applies for independent licensure in the future, they will be required to complete all required application documents and I will be requested to provide additional verification regarding their supervised practice.
- All information contained in this verification, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board rescinding the Board's approval of my clinical supervision of supervisee.

_____ _____
Signature of Supervisor Date

G SUPERVISEE ATTESTATION

I, _____ (Supervisee) certify that I have provided the behavioral health services and received the clinical supervision hours as reported above.

_____ _____
Signature of Supervisee Date

AGENCY USE ONLY	Approved ☐	*DUE DATE:*	*RECEIVED DATE:*