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

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF CLINICAL SUPERVISION FORM

IMPORTANT NOTES: Do not submit this form via email unless your supervisee is applying within the next **3** months or has already submitted an application. Rather, provide the form in a sealed envelope to the supervisee. The Board will not hold forms for more than **3** months. Emailed documents must come from the Clinical Supervisor, not the supervisee.

PART A. Complete the Supervisee Information section.

PART B. Complete the Clinical Supervisor Information section.

PART C. Provide the agency/practice setting name and contact information.

PART D. Complete the reporting period start and end date. Do not use CURRENT or PRESENT as the end date. If there are months that supervision was not provided during the reporting period, list them where indicated.

CLINICAL SUPERVISION HOURS

1. **Clinical Supervision** = 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.
2. **Individual Supervision** = clinical supervision provided by a Clinical Supervisor to one supervisee.
3. **Group of 2 supervisees** = clinical supervision provided by a Clinical Supervisor to 2 supervisees.
4. **Group of 3-6 supervisees** = clinical supervision provided by a Clinical Supervisor to a group of 3-6 supervisees.
5. **Direct observation** = clinical supervision involving the Clinical Supervisor observing the supervisee providing treatment and evaluation services to a client.

Carefully read the attestations and sign and date the form.

IMPORTANT: Clinical Supervisors who have not previously submitted their documents demonstrating their compliance with the Board's Clinical Supervisor education requirements must do so. Have you previously submitted your training documents to the Board for review OR are you included on the Board's Clinical Supervisor Registry ☐ Yes ☐ No

***NOTE**: If No, you must attach documents demonstrating compliance.*

The Clinical Supervisor may submit the form and documentation by email to applications@azbbhe.us, or provide them to the supervisee in a sealed envelope with a signature on the seal.

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

VERIFICATION OF CLINICAL SUPERVISION

PART A. SUPERVISEE INFORMATION

SALUTATION	LEGAL NAME (FIRST NAME LAST NAME)	
☐ MR. ☐ MS. ☐ MR. ☐ DR..		
CURRENT AZ BOARD LICENSE(S) #	ISSUE DATE(S)	EXPIRATION DATE(S)
EMAIL ADDRESS		PREFERRED PHONE

PART B. CLINICAL SUPERVISOR INFORMATION

SALUTATION	LEGAL NAME (FIRST NAME LAST NAME)	
☐ MR. ☐ MS. ☐ MR. ☐ DR..		
CURRENT AZ BOARD LICENSE(S) #	TITLE	DURING SUPERVISION I WAS: ☐ EMPLOYED BY THE SAME AGENCY/PRACTICE ☐ HIRED AS AN OUTSIDE CLINICAL SUPERVISOR*
EMAIL ADDRESS		PREFERRED PHONE

** NOTE: Applicants using a Clinical Supervisor who was not employed by the Agency/Practice where the supervision occurred must also submit the Clinical Supervisor Exemption Request form if not previously submitted and approved. This does not apply to Clinical Supervisors who were approved by the Board to provide Supervised Private Practice.*

PART C. PRACTICE SETTING

AGENCY/PRACTICE NAME	SUPERVISEE'S TITLE OR POSITION		
ADDRESS	CITY	STATE	ZIP CODE

During the supervision period, did you have an active license with the AZ Board of Behavioral Health Examiners? ☐ YES ☐ NO *If NO, please attach a verification of your credential. The verification must be from the regulating entity and include the professional's name, credential title and number, issue and expiration dates, credential status and past disciplinary actions.*

PART D. REPORT OF CLINICAL SUPERVISION HOURS

REPORTING PERIOD: _____ to _____
Start date *End date*
(do not use "current" or "present")

Was clinical supervision provided throughout the entire time period being verified above? ☐ YES ☐ NO
If NO, list the months that clinical supervision was not provided and give an explanation below:

CLINICAL SUPERVISION HOURS	
1. Total hours of **clinical supervision** *(including direct observation)* provided:	
2. Total hours of **individual supervision** *(from line 1.)* provided:	
3. Total hours of **group supervision of 2 supervisees** *(from line 1.)* provided:	
4. Total hours of **group supervision of 3-6 supervisees** *(from line 1.)* provided:	
5. Total hours of **direct observation of supervisee providing treatment** *(from line 1.)*:	

OVERALL RATING (must choose one):
Please consider the supervisee's skills in individual/group psychotherapy, psychoeducation, assessment, diagnosis and ethical conduct when determining your selection below.

☐ **Below satisfactory** ☐ **Satisfactory** ☐ **Above Satisfactory**

Explanation of above rating (optional):

SUPERVISOR ATTESTATION

I, _____ (Clinical Supervisor) certify that:

- _____ (Supervisee) was engaged in the supervised practice of behavioral health (including assessment, diagnosis and treatment) that met the Board's requirements as reported above.
- I have complied with the Board's Clinical Supervisor educational requirements and have remained in compliance for the reporting period above.
    - *Clinical Supervisors who are not included on the Board's registry must submit documentation demonstrating compliance*
- I have read and understand the clinical supervision requirements in A.A.C. R4-6-211 and R4-6-212 and certify 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.
- All information contained in this verification, including all supporting documents, 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 not accepting the clinical supervision hours I provided the applicant and/or denying the applicant's licensure application.

_____ _____
Signature of Supervisor Date

AGENCY USE ONLY	*RECEIVED DATE*	*STAFF INITIALS*