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 SUPERVISION FORM

IMPORTANT NOTES:

- This form is ONLY for master's level non-independent practitioners working under direct supervision in their own practice in which they have ownership 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.
- This form is not required for non-independent practitioners working under supervision in agencies/entities with responsibility and clinical oversight of the behavioral health services provided by the supervisee.
- The submission of the Verification of Supervision form does not preclude the supervisor's responsibility of verifying the entire supervised work experience period at the time of supervisee's application for independent level licensure. Both supervisor and supervisee should keep accurate records of the supervised hours and clinical supervision hours as required to meet the licensure requirements.

PART I. Complete the Supervisee Information section.

PART II. Complete the Clinical Supervisor Information section.

PART III. Provide the practice setting name and contact information. Provide a description of the services provided by the supervisee and whether or not their practice is a full time practice (30+ hours per week) or part time (<30 hours per week).

PART IV. Complete the reporting period start and end date. This time frame should match the reporting dates provided to you by the Board in your approval letter OR the termination date of your supervision if you have terminated your contract prior to the end of the reporting period.

SUPERVISED PRACTICE HOURS

1. **Supervised practice** = total hours of direct client services provided during the reporting period (should be the sum of #2 and #3).
2. **Direct client contact** = the 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.
3. **Direct client contact involving psychotherapy** = #2 above less any psychoeducation hours.

4. **Direct client contact involving psychoeducation** = #2 above less any psychotherapy hours. Psychoeducation means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health.

CLINICAL SUPERVISION HOURS

5. **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.
6. **Individual Supervision** = clinical supervision provided by a clinical supervisor to one supervisee.
7. **Group of 2 supervisees** = clinical supervision provided by a clinical supervisor to 2 supervisees.
8. **Group of 3-6 supervisees** = clinical supervision provided by a clinical supervisor to a group of 3-6 supervisees.
9. **On-site clinical supervision** = clinical supervision provided by a clinical supervisor in the practice setting of the supervisee (must be a minimum of once every 60 days).

Carefully read the attestations on page 2 of the form and sign and date the form.

Forms may be submitted electronically via fax at (602) 364-0890 or by email to SPP@azbbhe.us.

To submit by mail, send to: AZ Board of Behavioral Health Examiners
1740 W. Adams St, Suite 3600
Phoenix, AZ 85007

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VERIFICATION OF SUPERVISION

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PART I. SUPERVISEE INFORMATION

☐ MRS. ☐ MS. ☐ MR. ☐ DR.

LEGAL NAME (FIRST NAME, MI, LAST NAME)

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

☐ MRS. ☐ MS. ☐ MR. ☐ DR.

LEGAL NAME (FIRST NAME, MI, LAST NAME)

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. REPORT OF SUPERVISED PRACTICE

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

SUPERVISED PRACTICE HOURS	
1. Total hours of **direct client contact** involving psychotherapy and psychoeducation:	
2. Total hours of **direct client contact** *(from line 1.)* involving psychotherapy:	
3. Total hours of **direct client contact** *(from line 1.)* involving psychoeducation:	
CLINICAL SUPERVISION HOURS	
4. Total hours of **clinical supervision** provided:	
5. Total hours of **individual supervision** *(from line 4.)* provided:	
6. Total hours of **group supervision of 2 supervisees** *(from line 4.)* provided:	
7. Total hours of **group supervision of 3-6 supervisees** *(from line 4.)* provided:	
8. Total hours of **on-site clinical supervision** provided:	

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 understand that I will be monitoring the practice as well as providing direct and clinical supervision.
- I have complied with the Board's Clinical Supervisor educational requirements and have remained in compliance for the reporting period above.
- 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 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

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	*DUE DATE*	*RECEIVED DATE*