Professional Supervision Agreement For Associate Level Treatment Providers or Evaluators: *Adult and Juvenile Applicants*

You may copy this page.

Applicants Name:_____
Date:_____

Supervisor's Name:_____
Agency:_____
Address:_____
City, State, Zip_____
Telephone:_____
Fax:_____ Email:_____

Please note that a relative of the applicant shall not provide supervision.

I understand that _____ is practicing under my licensure and SOMB listing status, and that I am responsible for their clinical supervision. I have developed an individualized comprehensive supervision plan for _____ in accordance with the Competency-Based Provider Approval Model and will have it available for the Application Review Committee upon request.

Supervisor's signature_____ Date _____

Applicant's signature_____ Date _____

Please remember you must complete, sign and submit a new supervision agreement if your supervisor changes.