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

I understand that _____ is practicing under my licensure and SOMB listing
Print Applicant's Name

status, and that I am responsible for their clinical supervision. I am adhering to the SOMB Standards and Guidelines along with the Administrative Policies and have developed an individualized comprehensive supervision plan for _____ in accordance with the
Print Applicant's Name

Competency-Based Provider Approval Model and will have it available for the Application Review Committee upon request.

If any of your personal or professional information changes, you must report the information to the SOMB within two weeks.

The frequency of face-to-face supervision hours specific to sex offense specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Will you be utilizing alternate forms of supervision, i.e., phone, video conferencing?
Yes ◯ No ◯
If yes, please explain:

Applicant's Name (Please print clearly) _____

Applicant's signature: _____ **Date:** _____

Supervisor's Name (Please print clearly)_____

Supervisor's signature: _____ **Date:** _____