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 __________

Supervisor's Printed Name: __________________________________

Applicant's signature_________________________ Date __________

Applicant's Printed Name: ____________________________________

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