NORTH CAROLINA BOARD of LICENSED PROFESSIONAL COUNSELORS

P.O. Box 77819
Greensboro, NC 27417
TELEPHONE: 844-622-3572
FAX: 336-217-9450
http://www.ncblpc.org

Supervision Contract

Indicate to which LPC Associate this contract applies:

LPC Associate Name: _____ LPCA (#_____)

INSTRUCTIONS: FORMS MUST BE MAILED—NO FAXES OR EMAILS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this supervision contract.
2. **ALL SECTIONS** must be completed or the supervision contract will be returned.
3. The supervision contract should be mailed to the **NCBLPC Board Office at: NCBLPC, PO Box 77819, Greensboro, NC 27417**
4. This supervision **contract must be received and approved by the NCBLPC prior to initiation of supervision**.

Date Received: _____
Approved by: _____
Date Approved: _____

I. GENERAL INFORMATION - (*Supervisor Information)*

Supervisor's Name (Last, First, Middle): Tanner, Joy, Cone

(LPC, LCSW, etc.) LPCS

License Type/Number: S9355

Issuance Date: 09/25/2017

Mailing Address (Name of Workplace, Mailing Address, City, State, Zip Code):

Cornerstone Counseling and Wellness, PLLC

6604 Six Forks Rd, Suite 202, Raleigh, NC 27615

Business Phone: 919-523-9716

Email Address: joy@cornerstonecounselingnc.net

Mobile Phone: 919-523-9716

II. SUPERVISION - *To be completed by supervisor. Clinical Supervision is defined in Rules .0208 through .0212.*

Is this an exempt setting (school, university, government agency) ? ☐ **Yes** ■ **No**

Location of Supervision— provide name of workplace, physical address and a contact phone number:

Physical Address (Street, City, State, Zip Code): 6604 Six Forks Rd, Suite 202
Raleigh, NC 27615

Business Phone: 919-523-9716

Modality of Supervision to be Used - each supervision session shall utilize **at least one** of the following (check all that apply):

■ Live Observation/Supervision ■ Co-therapy ■ Audio Recording ☐ Video Recording

Frequency of Supervision (minimum one hour of individual or two hours of group supervision per 40 hours of counseling practice as defined in Rule .0208. At least three-quarters of the hours of clinical supervision shall be individual.):

The supervisee will receive a minimum of 1 hours of individual clinical supervision ■ weekly ☐ biweekly ☐ monthly

or a minimum of 2 hours of group clinical supervision ☐ weekly ☐ biweekly ■ monthly

Explanation of hours (if necessary): 1 hour of individual or 2 hours of group supervision per 40 hours worked

III. SUPERVISOR CREDENTIALING - *If proposed supervisor is a NC - Licensed Professional Counselor Supervisor (LPCS), skip to signatures.*

*The following documentation **must** be submitted with this Supervision Contract:*

Official transcript documenting the equivalent of 3 semester graduate credits in clinical supervision from a regionally accredited institution of higher education or 45 contact hours of continuing education in clinical supervision as defined by Rule .0603(c).

I agree to assume responsibility for the clinical work and preparation of this supervisee and will be available for consultation with the Board or its committees regarding the supervisee's competence.

Supervisor's Signature: _____ Date: _____

I understand and will abide by the requirements and expectations of supervision and the standards of clinical practice as defined by the Board.

Supervisee's Signature: _____ Date: _____