STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

PROPOSED SUPERVISION PLAN
CONDITIONAL LICENSURE

Name of Applicant:

SUPERVISION PLAN

Name of Supervisor:		Title:
Supervisor's License Number:		First Date of Issue:
Facility or Agency:		Work Telephone Number *(include area code)*:
Mailing Address:		
City:	State:	Zip Code:

SUPERVISION MUST EQUAL 1 HOUR/30 HOURS OF DIRECT COUNSELING SERVICE.

PLEASE DOCUMENT SPECIFIC PLANS THAT COVER THE FOLLOWING:
(Use separate sheet if needed)

Goals of Plan:

Objectives of Plan:

If providing clinical supervision for a clinical license, please focus on diagnosis and treatment:

I HEREBY ATTEST THAT THE ABOVE NAMED APPLICANT IS UNDER MY SUPERVISION FOR THE PERIOD BEGINNING_____. I ALSO ATTEST THAT ALL OF THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature: _____ Date: _____

Applicant's Signature: _____ Date: _____

PROPOSED SUPERVISION PLAN
CONDITIONAL LICENSURE

Name of Applicant:
Name of Supervisor:

To be completed by supervisor:

Number of years of counseling experience in the modality (e.g. clinical, marriage & family therapy, pastoral) which you intend to do supervision: _____

Answer one (1) or both of the following:

1. Describe training received in counseling supervision:

2. List the number of years and types of experiences in providing supervision to mental health professionals:

Please provide a separate written statement detailing your supervision philosophy, orientation and experience. The request for supervision will not be completed without the written statement.

I HEREBY ATTEST THAT ALL THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature: _____ Date: _____