FORM B
POST-MASTER'S SUPERVISION VERIFICATION

NO FAXED FORMS ACCEPTED • Please type or print clearly.

APPLICANT:

- Complete **Applicant** section and submit to your supervisor (BQS/LPC-S) for your post-master's supervised experience. If you have more than one work setting under which you completed your supervised experience, submit additional forms. This form may be photocopied.
- Mail the Form B from supervisor to the Board office at 239 North Lamar Street, Suite 402, Jackson, MS 39201.

SUPERVISOR:

- MS LPC-S complete the Form B online as detailed at https://lpc.ms.gov/secure/pdf/Website%20Supervision%20slides.pptx
- All other LPC-S
  - Complete **Supervisor** section, noting requirements. (2 pages)
  - Please enclose this form in a sealed envelope.
  - Sign your name over the flap and then mail it to the Applicant.
  - The supervisor must not be a member of the applicant's immediate family.
  - The supervisor must have assumed full responsibility for the clinical activities of the applicant for the duration of the supervised experience.

Do not forget to complete these steps.

Supervision Must Be:

- "Supervision" — the direct clinical review, for the purpose of teaching or training, of a professional counselor's interaction with client(s). The ongoing process performed by a BQS/LPC-S in assisting the counselor in developing expertise in methods of the professional mental health counseling practice and in developing self-appraisal and professional development strategies.
- One hour of supervision for every 25 hours direct client contact.
- In the practice of Professional Counseling.
- May be provided pro bono or for a fee.
- May be individual (one-on-one) or group (two to six supervisees).

Two group hours equals one individual. Report the TOTAL group hours and the Board will divide the total group hours by two.

APPLICANT

NAME: ______________________________ SOCIAL SECURITY NUMBER: ____________________

I hold a: ☐ Master's Degree ☐ Specialist Degree ☐ Doctorate Degree

SUPERVISOR

NAME: ______________________________ YEARS OF PRACTICE AFTER LICENSED: ____________

TYPE OF LICENSE: ☐ Licensed Professional Counselor ☐ Other ____________ BQS CERT # ____________

LICENSE #:________ STATE:______ DATE ISSUED:________ EXP. DATE:________ BQS CERT DATE:________

ADDRESS: ____
Street City State Zip

EMAIL: ____________________ TELEPHONE: (_____)____________ FAX: (_____) ____________

CERTIFICATION OF SUPERVISION:
I hereby certify that I supervised the Professional Counseling practice of the above-named Applicant during the following period(s):

FROM ______________ TO ______________ LOCATION ______________________________

TOTAL HOURS*: ________ DIRECT CONTACT: ________ INDIVIDUAL SUPERVISION: ________ GROUP SUPERVISION: _______

*Total Hours = sum of direct hours, indirect hours, individual supervision, and group supervision.

At the time of supervision the applicant's employment was (check only one)

☐ FULL TIME ☐ PART TIME AT ________ %

Board Office Use Only
☐ Envelope Sealed & Signed
☐ Signature Matches Form

DESCRIPTION OF PRACTICE SUPERVISED: (Please provide detailed description of your supervision that complies to Rule 4.5., which includes experience in supervision, strengths/areas of growth, oral/written communication, etiology ad diagnosis, professional and ethical practices, etc.)

RECOMMENDATION AND VERIFICATION:

I, the undersigned Supervisor or authorized representative, attest that I provided the supervision described above- that this is a true and accurate representation of that supervision and that I:

☐ Recommend, without reservation, that the applicant be considered for licensure.

☐ Recommend with some reservations, that the applicant be considered for licensure. ☐ Explanation attached.

☐ Do Not Recommend that the applicant be considered for licensure. ☐ Explanation attached.

______________________________ ____

Date Signature of Supervisor

Sworn to and subscribed before me this _______day of ________________, ______.

____

Notary Public

My Commission Expires:________________

NOTARY SEAL