



Board of Behavioral Sciences

1625 North Market Blvd., Suite S200, Sacramento, CA 95834

Telephone: (916) 574-7830 TTY: (800) 326-2297

www.bbs.ca.gov


SUPERVISORY PLAN

Title 16, California Code of Regulations (CCR) Sections 1870.1 and 1822 require all associate clinical social workers and professional clinical counselor interns/associates and licensed mental health professionals acceptable to the Board as defined in Business and Professions Code Section 4996.23(a), 4999.12(h), and CCR Section 1874, who assume responsibility for providing supervision to those working toward a license as a Clinical Social Worker or Professional Clinical Counselor to complete and sign the following supervisory plan. The original signed plan shall be submitted by the registrant to the board upon application for examination eligibility.

REGISTRANT: (Please type or print clearly in ink.)

Legal name:	Last	First	Middle	Registration Number
Address:	Number and Street			
City	State		Zip Code	
Business Telephone ()	Residence Telephone ()			

LICENSED SUPERVISOR: (Please type or print clearly in ink.)

Name:	Last	First	Middle	License No:	Expiration Date:																				
Employer Name:	Telephone Number: ()																								
Address:	Number and Street																								
City	State		Zip Code																						
Employment Setting:	<table border="0"> <tr> <td>a. Private Practice</td> <td><input type="checkbox"/></td> <td>d. Licensed Health Facility</td> <td><input type="checkbox"/></td> </tr> <tr> <td>a. Governmental Entity</td> <td><input type="checkbox"/></td> <td>e. Social Rehabilitation Facility/Community Treatment Facility</td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Nonprofit and Charitable Corporation</td> <td><input type="checkbox"/></td> <td>f. Pediatric Day Health and Respite Care Facility</td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. School, College, or University</td> <td><input type="checkbox"/></td> <td>g. Licensed Alcoholism or Drug Abuse Recovery or Treatment Facility</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>h. Community Mental Health Facility</td> <td><input type="checkbox"/></td> </tr> </table>					a. Private Practice	<input type="checkbox"/>	d. Licensed Health Facility	<input type="checkbox"/>	a. Governmental Entity	<input type="checkbox"/>	e. Social Rehabilitation Facility/Community Treatment Facility	<input type="checkbox"/>	b. Nonprofit and Charitable Corporation	<input type="checkbox"/>	f. Pediatric Day Health and Respite Care Facility	<input type="checkbox"/>	c. School, College, or University	<input type="checkbox"/>	g. Licensed Alcoholism or Drug Abuse Recovery or Treatment Facility	<input type="checkbox"/>			h. Community Mental Health Facility	<input type="checkbox"/>
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Briefly describe the goals and objectives:

I certify that I understand the responsibilities regarding clinical supervision, including the supervisor's responsibility to perform ongoing assessments of the supervisee, and I declare under penalty of perjury under the laws of the State of California that the information submitted on this form is true and correct.

Supervisor's Signature

Date signed

Registrant's Signature

Date signed

The **original** of this form must be submitted to the board upon application for examination eligibility.