



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
VERIFICATION OF POST DEGREE
COUNSELING EXPERIENCE

COMMITTEE FOR PROFESSIONAL COUNSELORS
 3605 MISSOURI BOULEVARD
 P.O. BOX 1335
 JEFFERSON CITY, MO 65102-1335

INSTRUCTIONS **PLEASE TYPE OR PRINT IN BLACK INK**

APPLICANT: Complete items 1-4 and forward this form to all supervisors in order verify supervised counseling experience. Additional forms may be requested from the committee office and are available online at <http://pr.mo.gov/counselors.asp>.

SUPERVISOR: Please complete sections II and III. Please return to:
 COMMITTEE FOR PROFESSIONAL COUNSELORS
 3605 MISSOURI BOULEVARD
 POST OFFICE BOX 1335
 JEFFERSON CITY, MO 65102-1335.

Telephone: (573) 751-0018 (voice mail) **FAX:** (573) 751-0735 **TDD:** 800-735-2966 **Email:** profcounselors@pr.mo.gov

I. APPLICANT DATA

1. NAME (LAST, FIRST, MIDDLE, MAIDEN)	2. EMAIL ADDRESS
3. ADDRESS (STREET, BOX NUMBER, CITY, STATE, ZIP CODE)	4. PROVISIONAL LICENSE # (IF APPLICABLE)

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION REQUESTED BELOW TO THE MISSOURI COMMITTEE FOR PROFESSIONAL COUNSELORS.

5. SIGNATURE OF APPLICANT ▶	SOCIAL SECURITY NUMBER	DATE
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APPLICANT DO NOT WRITE BELOW THIS LINE – FOR SUPERVISOR’S COMPLETION ONLY

II. SUPERVISOR SECTION

Complete items below and return the original (not a photocopy) of this supervision verification form to Missouri Committee for Professional Counselors. **DO NOT RETURN THIS FORM TO THE APPLICANT.** You must verify all hours worked under your supervision.

6. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	7. TELEPHONE NUMBER
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8. CURRENT WORK ADDRESS

9. PLEASE INDICATE BELOW PROFESSIONAL LICENSURES THAT APPLY TO THE SUPERVISOR.

	LICENSE STATE	LICENSE NUMBER
<input type="checkbox"/> LICENSED PROFESSIONAL COUNSELOR		
<input type="checkbox"/> LICENSED PSYCHOLOGIST		
<input type="checkbox"/> LICENSED PSYCHIATRIST		

10. LIST SITE THE APPLICANT PROVIDED PROFESSIONAL COUNSELING EXPERIENCE UNDER YOUR SUPERVISION.

AGENCY/FACILITY	DATE FROM (MONTH/YR)	DATE TO (MONTH/YR)
ADDRESS (STREET, CITY, STATE ZIP)		

ONE HOUR PER WEEK FACE-TO-FACE SUPERVISION REQUIRED. 50% MUST BE INDIVIDUAL SUPERVISION. REMAINING HOURS CAN BE INDIVIDUAL OR GROUP SUPERVISION.

	HOURS OBTAINED
A. TOTAL HOURS OF DIRECT CLIENT CONTACT UNDER SUPERVISION DURING ENTIRE SUPERVISION PERIOD	
B. TOTAL HOURS APPLICANT PERFORMED COUNSELING DUTIES UNDER YOUR SUPERVISION DURING ENTIRE SUPERVISION PERIOD TO INCLUDE DIRECT CLIENT CONTACT.	
C. DID YOU MEET AT LEAST ONE HOUR PER WEEK WITH THE APPLICANT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE CHECK ONE BELOW.	
<input type="checkbox"/> ALL SUPERVISORY MEETINGS WERE WITH THE APPLICANT FOR AT LEAST ONE HOUR PER WEEK. NO GROUP SUPERVISION WAS PROVIDED.	
<input type="checkbox"/> WEEKLY SUPERVISION MEETINGS CONSISTED OF INDIVIDUAL AND GROUP SUPERVISION. PLEASE PROVIDE A BREAKDOWN OF SUPERVISION _____ % INDIVIDUAL _____ % GROUP	

TITLE(S) APPLICANT HELD DURING SUPERVISION

11. CHECK ALL OF THE APPROPRIATE BOXES INDICATING THE NATURE OF COUNSELING DUTIES PERFORMED BY THE APPLICANT:

- ASSESSMENT/TESTING CRISIS INTERVENTION GROUP COUNSELING
 INDIVIDUALS (Please specify) _____ ADOLESCENTS _____ ADULTS _____ CHILDREN _____ FAMILY
 RESEARCH SCHOOL COUNSELING SUBSTANCE ABUSE COUNSELING
 VOCATIONAL/CAREER OTHER (Please explain) _____

12. DID YOU READ AND COSIGN ALL WRITTEN REPORTS, IF NO PLEASE EXPLAIN?

YES

NO

13. INDICATE YOUR EVALUATION OF THE COUNSELOR-IN-TRAINING OR PLPC BY PLACING A CHECKMARK IN THE APPROPRIATE COLUMN.

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AVERAGE

ABOVE
AVERAGE

VERY
GOOD

A. SUBSTANTIVE KNOWLEDGE OF THE PRACTICE OF PROFESSIONAL COUNSELING.

B. ABILITY TO ESTABLISH AND MAINTAIN GOOD INTERPROFESSIONAL RELATIONS.

C. POSSESSION OF EMOTIONAL MATURITY, STABILITY, AND TEMPERAMENTAL CHARACTERISTICS REQUIRED FOR PERFORMANCE AS A PROFESSIONAL COUNSELOR

D. UNDERSTANDING OF AND ADHERENCE TO APPROVED STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT.

E. PERSONAL CHARACTER: HONESTY, INTEGRITY AND GENERAL CONDUCT.

F. REPUTATION AMONG COLLEAGUES.

G. CAPACITY FOR PROFESSIONAL GROWTH AND DEVELOPMENT

H. I WOULD RATE THIS APPLICANT'S OVERALL PERFORMANCE UNDER BY SUPERVISION AS:

14. RECOMMENDATION FOR LICENSURE

- WITHOUT RESERVATION DO NOT RECOMMEND (ATTACH EXPLANATION)
 WITH RESERVATION (ATTACH EXPLANATION)

III. SUPERVISOR ATTESTATION

I hereby affirm under penalties of perjury that I am the supervisor named in this verification and that all statements and enclosures herein are true and accurate to the best of my knowledge, information and belief.

SIGNATURE

DEGREE

DATE

FOR OFFICIAL USE ONLY