STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
CHANGE OF SUPERVISOR AND/OR SITE

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

INSTRUCTIONS

PLEASE ENTER RESPONSES IN BLACK INK WITH ALL SECTIONS COMPLETED. FAILURE TO COMPLETE A SECTION WILL RESULT IN THE APPLICATION BEING RETURNED AND DELAY COMMITTEE REVIEW. THE FEE IS **$25** AND SUPERVISION IS CONSIDERED EFFECTIVE THE DATE THIS FORM AND FEE ARE RECEIVED IN THE COMMITTEE OFFICE. THIS APPLICATION MUST BE MAILED WITH THE **$25** FEE. **DO NOT FAX OR EMAIL THIS APPLICATION.** PLEASE SEE INSTRUCTIONS AT PR.MO.GOV/COUNSELORS AND CLICK ON APPLICATION FORMS ICON.

I. APPLICANT INFORMATION

TYPE OF CHANGE (CHECK ALL APPLICABLE BOXES)

☐ ADDITIONAL SUPERVISOR ☐ NEW SUPERVISOR ☐ ADDITIONAL SITE ☐ NEW SITE

1. NAME (LAST, FIRST, MIDDLE, MAIDEN NAME)		2. EMAIL ADDRESS
3. DAYTIME PHONE NUMBER	4. DATE OF BIRTH	5. SOCIAL SECURITY NUMBER
6. PREFERRED MAILING ADDRESS (STREET, BOX NUMBER, CITY, STATE, ZIP CODE)		
7. ENTER PROVISIONAL LICENSURE NUMBER (IF APPLICABLE)		

II. SUPERVISOR INFORMATION

8. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	9. IS SUPERVISOR A RELATIVE OF APPLICANT? ☐ YES ☐ NO
10. ADDRESS (STREET)	CITY, STATE, ZIP CODE
11. DAYTIME PHONE NUMBER	12. EMAIL ADDRESS

13. PLEASE CHECK ALL THAT APPLY TO SUPERVISOR:

☐ LICENSED PROFESSIONAL COUNSELOR	LICENSE NUMBER	STATE
☐ LICENSED PSYCHOLOGIST	LICENSE NUMBER	STATE
☐ LICENSED PSYCHIATRIST	LICENSE NUMBER	STATE
☐ OTHER LICENSE PLEASE SPECIFY _____	LICENSE NUMBER	STATE

III. SUPERVISED PRACTICE SITE

14. SITE NAME	
15. SITE ADDRESS (STREET)	CITY, STATE, ZIP CODE

16. SITE DESCRIPTION

☐ COMMUNITY HEALTH/MENTAL HEALTH
☐ HOSPITAL
☐ SCHOOL (PLEASE ATTACH SUMMER PLAN)
*PLEASE REGISTER BOTH THE SCHOOL AND A HEALTH AGENCY, IF YOUR SCHOOL IS AFFILIATED WITH A HEALTH AGENCY
☐ CORRECTIONS
☐ PRIVATE PRACTICE (SECTION 19)
☐ VETERANS FACILITY
☐ LEASED OFFICE SPACE
☐ RESIDENTIAL FACILITY
☐ VOCATIONAL REHAB
☐ OTHER-SUBMIT SITE DESCRIPTION ON SEPARATE SHEET OF PAPER AND INCLUDE WITH APPLICATION

16A. IS YOUR LICENSURE SUPERVISOR EMPLOYED BY THE PRACTICE SITE? **IF NO, YOU MUST INCLUDE A MODEL CONTRACT AFFILIATING SUPERVISOR TO THE SITE.**

☐ YES ☐ NO

17. IS SITE A PRIVATE PRACTICE? IF YES, ANSWER QUESTIONS 18 AND 19 BELOW.

☐ YES ☐ NO

18. LIST ALL INDIVIDUALS EMPLOYED BY OR AFFILIATED WITH THE PRIVATE PRACTICE (attach separate sheet, if necessary.)

NAME	TITLE	LICENSE NUMBER	STATUS

19. IDENTIFY INDIVIDUAL(S) WHO HAVE AN OWNERSHIP INTEREST IN THE PRIVATE PRACTICE.	**OFFICE USE ONLY**

IV. NATURE OF SUPERVISED COUNSELING

20. SUPERVISOR AND SUPERVISEE MUST REVIEW AND CHECK BOXES.

☐ By checking this box - I, the supervisor, attest and understand that of the amount of supervision hours this applicant works at this site, while under my supervision, they will obtain an average of at least fifteen (15) hours of supervised counseling experience per week.

☐ By checking this box - I, the supervisee, attest and understand that of the amount of supervision hours that I work at this site, while under my supervisor, I will provide an average of at least fifteen (15) hours of supervised counseling experience per week.

21. APPLICANT'S WORK TITLE

22. DATE OF **APPLICANT'S** INITIAL EMPLOYMENT	23. ESTIMATED HOURS PER WEEK WORKING AT COUNSELING SITE. MUST WORK AT LEAST FIFTEEN (15) HOURS PER WEEK.

24. HOW ARE MEDICAL/CLIENT RECORDS STORED OR MAINTAINED? CHECK ALL THAT ARE APPLICABLE.

☐ EMR (electronic medical record) ☐ Hard copy (paper) ☐ Both

V. APPLICANT HISTORY

25. **PLEASE ANSWER THE FOLLOWING QUESTIONS.**

NOTE: (Yes answers **MUST** be explained in writing on a separate sheet of paper and attached to this application)

	YES	NO
a. Have you ever taken an examination or been licensed by another professional licensing board? If yes, please list the board name, state, and license number._____	☐	☐
b. Have you, or any license or right to practice held by you, been restricted or disciplined. Such a disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any US state, territory, federal agency, Canadian province or foreign country?	☐	☐
c. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold?	☐	☐
d. Have you ever been arrested, charged, subject to prosecution, indicted, found guilty, or entered a plea of guilty or nolo condendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed? You must answer "yes" even if a suspended imposition of sentence or suspended execution of sentence was received/ordered.	☐	☐
e. Have you been charged with or convicted of a violation of any federal or state drug law or rule whether or not sentence was imposed or suspended?	☐	☐
f. Are you now or have you in the last five years been addicted to any drug or chemical substance including alcohol?	☐	☐
g. Have you had a judgment rendered against you based upon fraud, misrepresentation, or deception related to the practice of counseling?	☐	☐
h. Have you ever been named as a defendant in a civil suit related to counseling?	☐	☐

26.

Pursuant to Section 324.010 RSMo:

☐ **CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

False statements are subject to criminal penalties and/or license discipline.

Information relating to state income tax compliance should be directed to the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

VI. STATEMENT OF APPLICANT (ORIGINAL SIGNATURE REQUIRED)

- I hereby affirm under penalties of perjury that I am the applicant named in this registration and that all statements and enclosures herein are true and accurate to the best of my knowledge, information and belief.
- I certify that I have read the laws and applicable rules promulgated by the Missouri Committee for Professional Counselors.
- I submit for consideration this application for supervision and provisional licensure as required by the Missouri law governing the practice of professional counseling and subject to the rules of the Missouri Committee for Professional Counselors.
- I subscribe and agree to abide by all applicable laws and rules regarding the practice of professional counseling.
- I understand I must practice professional counseling under the supervision of a licensed professional counselor, psychologist, or psychiatrist approved by the Committee for Professional Counselors until I am licensed. **If, for any reason, the approved site or supervisor changes, I will notify the Committee for Professional Counselors and file a change of supervision application, within 15 days. I understand that any supervision obtained without such notification will not be applicable towards licensure.**
- I understand all correspondence regarding this application will be provided to the licensure supervisor.
- I authorize all correspondence regarding this application to be emailed to the supervisor and me at the email addresses listed on this application. I understand such correspondence will not be sent via regular mail.

APPLICANT SIGNATURE (REQUIRED)	DATE

VII. STATEMENT OF SUPERVISOR

27. TO BE COMPLETED BY SUPERVISOR. CHECK ALL BOXES APPLICABLE TO DOCUMENTATION TO BE REVIEWED AND HOW SUPERVISION WILL BE CONDUCTED.

DOCUMENTATION REVIEW	SUPERVISION
☐ Assessments	☐ Distance Supervision (If this box is checked, supervisor must submit name of software used, education and/or training in distance supervision, and how documentation will be reviewed. Please submit written explanation with this application)
☐ Progress Notes	☐ Group Supervision
☐ Reports	☐ Individual Supervision
☐ Treatment Plans	☐ Observe Counseling Sessions
☐ Documentation not available for supervisor review (please explain below)	☐ Outreach/Engagement
	☐ Review Audio/Video Recording of Sessions
	☐ Other (please explain on separate sheet of paper and attach to form)

Documentation must be reviewed by the licensure supervisor and cannot be delegated to another individual.

I have reviewed this application and accept full responsibility for the counseling and counseling related work provided by the applicant. Counseling will be provided according to all applicable law and rules regarding counseling and licensure supervision. If supervision is discontinued, I will submit a Verification of Post Degree Experience Application to the committee office.

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

SUPERVISOR SIGNATURE (REQUIRED)	DATE