STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
APPLICATION FOR SUPERVISION

RETURN APPLICATION AND FEE TO:
COMMITTEE FOR PROFESSIONAL COUNSELORS
3605 MISSOURI BOULEVARD
PO BOX 1335
JEFFERSON CITY, MO 65102-1335
PROFCOUNSELOR@PR.MO.GOV

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 $75 and supervision is considered effective the date this form and fee are received in the committee office and contingent upon receipt of an official graduate transcript within 30 days of receipt of the application and fee. This application must be mailed with the $75 fee. **DO NOT FAX OR EMAIL THIS APPLICATION.** Please see checklist at pr.mo.gov/counselors and click on Application Forms icon.

Pursuant to §324.024, RSMo, disclosure of your Social Security Number (SSN) is mandatory. The committee will not publicly disclose your SSN without your consent, unless such disclosure is permitted by federal or state law. However, state law allows the committee to disclose your SSN in connection with any civil, criminal, administrative or arbitral proceeding, in an investigation in anticipation of litigation, pursuant to a court order, and in the performance of the statutory or constitutional duty or power. The committee can also disclose your SSN to another governmental agency (federal, state or local) and to a private person or entity acting on behalf of, or in cooperation with, a state entity. State law requires the committee to provide your SSN to child support and tax compliance officials.

I. APPLICANT INFORMATION

1. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN) (USE CURRENT NAME, PLEASE INCLUDE SURNAME ON TRANSCRIPT(S) IF DIFFERENT)

Smith, Jane E (maiden name: Jones) (Surname on Transcript: Jones)

2. E-MAIL ADDRESS

Jane.Smith@nowhere.com

3. ADDRESS (STREET AND BOX NUMBER, IF APPLICABLE)	CITY, STATE, ZIP
123 Street Drive	Town, MO 65000

4. DAYTIME TELEPHONE NUMBER	5. DATE OF BIRTH	6. SOCIAL SECURITY NUMBER (REQUIRED)
(573) 000-0000	01/01/2000	000-00-0000

7. GENDER (THIS INFORMATION IS VOLUNTARY)	8. RACE (THIS INFORMATION IS VOLUNTARY)
F	C

9. HAVE YOU PASSED THE NATIONAL COUNSELOR EXAMINATION (NCE)

☐ Yes Date: _____ (MM/YY) ☑ No

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 must be directed to MO Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

☐ **Please check here if you are active duty military service member, retired military, or honorably discharged veteran.**

☐ **Please check here if you are the spouse of an active duty military service member, retired military or honorably discharged veteran.**

Pursuant to section 324.015.2 RSMo an applicant can be eligible for a waiver of the application fee upon providing documentation of active military, retired or honorably discharged veteran or the spouse of the any aforementioned. *(If applicable, a fee is not required.)*

II. 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.

ORIGINAL APPLICANT SIGNATURE (REQUIRED)	DATE	OFFICE USE ONLY
Jane Smith	08/01/2022	

10. APPLICANT NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN)
Smith, Jane (Jones)

III. SUPERVISOR INFORMATION

11. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	12. DAYTIME PHONE NUMBER	13. IS SUPERVISOR A RELATIVE OF APPLICANT?
Johnson, John	(573) 000-0000	☐ YES ☑ NO

14. ADDRESS (STREET)	CITY, STATE, ZIP CODE
456 Nowhere St.	Town, MO 65000

15. SUPERVISOR EMAIL ADDRESS
John.johnson@nowhere.com

16. PLEASE CHECK ALL THAT APPLY TO SUPERVISOR:

	LICENSE NUMBER	STATE
☑ LICENSED PROFESSIONAL COUNSELOR	123123123	TN
☐ LICENSED PSYCHOLOGIST		
☐ LICENSED PSYCHIATRIST		
☑ OTHER (list credential) Massage Therapy	123456123	CO

IV. PRIMARY PRACTICE SITE

17. NAME OF PRACTICE SITE	17A. IS THE SUPERVISOR EMPLOYED AT THIS SITE?
Counseling Place	☑ Yes ☐ No If no, a model contract is needed: https://pr.mo.gov/boards/counselors/Model_Contract.pdf

18. SITE ADDRESS	CITY, STATE, ZIP CODE
456 Nowhere St.	Somewhere, MO 65000

19. **APPLICANT'S** WORK TITLE	20. DATE OF **APPLICANT'S** INITIAL EMPLOYMENT	21. ESTIMATED HOURS PER WEEK WORKING AT COUNSELING SITE
License Professional Counselors	08/01/2022	20

22. 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 23)
☐ VETERANS FACILITY
☐ LEASED OFFICE SPACE
☐ RESIDENTIAL FACILITY
☐ VOCATIONAL REHAB
☐ OTHER-SUBMIT SITE DESCRIPTION ON SEPARATE SHEET OF PAPER AND INCLUDE WITH APPLICATION

23. IF SITE IS A PRIVATE PRACTICE, LIST ALL INDIVIDUALS EMPLOYED BY OR AFFILIATED WITH THE PRIVATE PRACTICE. (ATTACH SEPARATE SHEET IF NECESSARY)

NAME	TITLE	LICENSE NUMBER

NATURE OF SUPERVISED COUNSELING

24. **DIRECT CLIENT CONTACT** SUPERVISOR AND SUPERVISEE MUST REVIEW AND CHECK THE 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.

(Example of types of direct client hours: Career Counseling, Group Counseling, School Counseling, Substance Abuse Counseling, etc.)

(Example of types of counseling-related hours (i.e., indirect hours): Crisis Intervention (telephone), case management, Professional Development, research, Outreach/engagement, Test/appraisal administration)

V. SECONDARY PRACTICE SITE (if applicable)

25. NAME OF PRACTICE SITE	26. IS THE SUPERVISOR EMPLOYED AT THIS SITE? ☐ Yes ☐ No If no, a model contract is needed: https://pr.mo.gov/boards/counselors/Model_Contract.pdf
27. SITE ADDRESS	CITY, STATE, ZIP CODE
28. **APPLICANT'S** WORK TITLE	
29. DATE OF **APPLICANT'S** INITIAL EMPLOYMENT	30. ESTIMATED HOURS PER WEEK WORKING AT COUNSELING SITE

31. 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 31)
☐ VETERANS FACILITY

☐ LEASED OFFICE SPACE
☐ RESIDENTIAL FACILITY
☐ VOCATIONAL REHAB
☐ OTHER-SUBMIT SITE DESCRIPTION ON SEPARATE SHEET OF PAPER AND INCLUDE WITH APPLICATION

32. IF SITE IS A PRIVATE PRACTICE, LIST ALL INDIVIDUALS EMPLOYED BY OR AFFILIATED WITH THE PRIVATE PRACTICE. (ATTACH SEPARATE SHEET IF NECESSARY)

NAME	TITLE	LICENSE NUMBER	STATUS

NATURE OF SUPERVISED COUNSELING

33. **DIRECT CLIENT CONTACT** SUPERVISOR AND SUPERVISEE MUST REVIEW AND CHECK THE 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.

(Example of types of direct client hours: Career Counseling, Group Counseling, School Counseling, Substance Abuse Counseling, etc.)

(Example of types of counseling-related hours (i.e., indirect hours): Crisis Intervention (telephone), case management, Professional Development, research, Outreach/engagement, Test/appraisal administration)

VI. GRADUATE EDUCATION

OFFICIAL TRANSCRIPTS FOR ALL GRADUATE WORK REQUIRED (TRANSCRIPTS ARE ONLY ACCEPTED DIRECTLY FROM THE SCHOOL, OR IN AN OFFICIAL SCHOOL SEALED ENVELOPE FROM THE APPLICANT)

34. List the emphasis/major of the program as listed on the graduate transcript

A. If the program was accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or Council on Rehabilitation Education (CORE), please check here ☐ Skip B & C, if you checked this box.

B. If graduate course is in quarter hours, please check here ☐

C. If **any** graduate course work was online, distance based, or a hybrid format, please check here ☑

**Please have the program provide each on-line course(s) number, title and description on program letterhead showing the course is synchronized both visually and verbally.*

CACREP APPROVED PROGRAMS DO NOT HAVE TO SUPPLY COURSE/HYBRID DESCRIPTION(S).

DEGREE INFORMATION

UNIVERSITY/COLLEGE ATTENDED (Do not list undergraduate course work)	CITY AND STATE	DATES ATTENDED FROM MON	FROM YR	TO MON	TO YR	DEGREE TYPE	CONFERRED MO	CONFERRED YR
A. Help University	Somewhere MO	08	17	05	22	BA	05	22
B. Ability University	Place MO	08	22	05	24	MA	05	24
C.								

NON-CACREP/CORE APPROVED PROGRAMS MUST LIST CORE COURSES TAKEN FOR GRADUATE CREDIT THAT APPEAR ON A TRANSCRIPT.

- One course can only be used for one core area
- If the course title does not clearly align with the name of the core requirement, please provide a syllabus
- If course title does not align with a core requirement, contact your counseling program

☐ Check this box if your program is CACREP approved, you may skip this section and go to #35.

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN
A. ASSESSMENT (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO400	Ability University	Assessments Techniques	1	8/22
CO410	Ability University	Intro psychological measurement (Course work attached)	2	8/23
B. CAREER COUNSELING (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO420	Ability University	Career Counseling	1	8/22
CO425	Ability University	Intro counseling across Living Big (syllabi attached)	2	1/23
C. COUNSELING THEORY (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO500	Ability University	Counseling Theories	3	8/24
D. COUNSELING SKILLS AND INTERVENTIONS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO501	Ability University	Introduction to mental health counseling	3	8/23
E. DIAGNOSIS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO502	Ability University	Abnormal Psychology: Theory, Diagnosis and Treatment	3	8/24
F. HUMAN GROWTH AND DEVELOPMENT (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO503	Ability University	Life Span Development	3	8/23
G. GROUP COUNSELING (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO504	Ability University	Theory and Methods of Group Counseling	3	8/23
H. SOCIAL AND CULTURAL DIVERSITY (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO505	Ability University	Multicultural issues in Counselng	3	8/22
I. RESEARCH METHODS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO506	Ability University	Research Methods and Statistics	3	8/24
J. PRACTICUM/INTERNSHIP (MINIMUM 6 SEMESTER HOURS GRADUATE CREDIT REQUIRED.)				
CO507	Ability University	Supervised Counseling Practicum	3	8/24
CO508	Ability University	Supervised Counseling Internship	3	1/24
K. PROFESSIONAL ORIENTATION AND ETHICS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
CO510	Ability University	Professional Orientation and Ethics	3	1/23

VII. APPLICANT HISTORY

35. **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?	☐	☑

VIII. STATEMENT OF SUPERVISOR (ORIGINAL SIGNATURE REQUIRED)

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

DOCUMENTATION REVIEW AND COSIGNED	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)	☐ Review Audio/Video Recording of Sessions
	☐ Other (please explain below)

37. ☑ AS A LICENSURE SUPERVISOR, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTINUE SUPERVISION WITH THE SUPERVISEE UNTIL THEY ARE FULLY LICENSED.

Documentation throughout supervision, must be reviewed and cosigned by you, as the licensure supervisor, and cannot be delegated to another individual at the site.

TERMS AND CONDITIONS FOR SUPERVISORS

38. By signing below, I acknowledge that:

- 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 laws 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
John Johnson	08/01/2022