STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

VERIFICATION OF POST DEGREE SUPERVISED COUNSELING EXPERIENCE

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

SUPERVISOR: Please enter responses in black ink with all sections completed. This form is to be completed by the licensure supervisor and the original mailed to the address on this form. Failure to complete a section will result in the application being returned and delay committee review. A verification of post degree supervised experience form is required for each supervisor and each setting. **DO NOT FAX OR EMAIL THIS APPLICATION**. Please see the Checklist provided at https://pr.mo.gov/counselors-application-forms.asp

I. LICENSURE APPLICANT INFORMATION

1. APPLICANT NAME (LAST, FIRST, MIDDLE)	2. PROVISIONAL LICENSE NUMBER (IF APPLICABLE)

3. ADDRESS (STREET, BOX NUMBER)	3A. CITY, STATE, ZIP CODE

4. TELEPHONE	5. EMAIL ADDRESS

6.
☐ I understand that I must remain under supervision with my current supervisor until the Committee has approved me for licensure.

APPLICANT DO NOT WRITE BELOW THIS LINE – FOR SUPERVISOR'S COMPLETION ONLY

II. LICENSURE SUPERVISOR INFORMATION

Complete items below and return the original (not a copy) of this supervision verification form to Missouri Committee for Professional Counselors. This form can be sent to the committee office with the application for licensure or separately. The applicant will have access to this form.

7. LICENSURE SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)	8. TELEPHONE NUMBER

9. MAILING ADDRESS	10. CITY, STATE, ZIP CODE

11. EMAIL ADDRESS

12. Supervisor License Information

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

III. SUPERVISED COUNSELING INFORMATION

13. SUPERVISED SITE NAME

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

16. START DATE (MM/DD/YYYY) (THE START DATE IS WHEN THE COMMITTEE APPROVED YOUR SUPERVISION.)	17. END DATE (MM/DD/YYYY)

	HOURS OBTAINED
18. ENTER HOURS OF **DIRECT CLIENT CONTACT** DURING TIMEFRAME LISTED IN 16 AND 17.	
19. ENTER HOURS APPLICANT PROVIDED **INDIRECT COUNSELING RELATED ACTIVITIES** DURING TIMEFRAME LISTED IN 16 AND 17. DO **NOT** INCLUDE THE DIRECT CLIENT CONTACT HOURS.	
20. ADD ITEMS #18 (DIRECT CLIENT CONTACT) AND #19 (INDIRECT CLIENT CONTACT RELATED ACTIVITIES) AND ENTER THE RESULT TOTAL.	TOTAL

21. DID YOU MEET AT LEAST ONE HOUR PER WEEK WITH THE APPLICANT?
☐ YES ☐ NO

21A. WERE ANY ONE HOUR WEEKLY SUPERVISORY MEETINGS PROVIDED ONLINE OR DISTANCE BASED?
☐ YES ☐ NO IF NO, PROCEED TO ITEM #22. IF YES, WAS THE ONLINE OR DISTANCE SUPERVISION PREVIOUSLY DISCLOSED?
☐ YES ☐ NO IF NO, PLEASE PROVIDE WRITTEN EXPLANATION BELOW.

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22. ☐ ALL SUPERVISORY MEETINGS WERE WITH THE APPLICANT FOR AT LEAST ONE HOUR PER WEEK. NO GROUP SUPERVISION WAS PROVIDED.

23. ☐ WEEKLY SUPERVISION MEETINGS CONSISTED OF INDIVIDUAL AND GROUP SUPERVISION. PLEASE PROVIDE A BREAKDOWN OF SUPERVISION _____ % INDIVIDUAL _____ % GROUP

24. DOCUMENTATION REVIEW	25. SUPERVISION
☐ Assessments	☐ Distance Supervision *(If this box is checked, submit name of software used, and how documentation was 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 *	☐ Outreach/Engagement
☐ Other (please describe below)	☐ Review Audio/Video Recording of Sessions
	☐ Other (please describe below)

* Documentation must be reviewed by the licensure supervisor and cannot be delegated to another individual. *Please provide a written explanation, on a separate sheet of paper and explain why documentation was not reviewed.*

26. INDICATE YOUR EVALUATION OF THE COUNSELOR-IN-TRAINING OR PLPC BY PLACING A CHECKMARK IN THE APPROPRIATE COLUMN. *NOTE: THE BULLET POINTS IN ITALICS VERIFY AREAS TO BE CONSIDERED WHEN RATING THE APPLICANT.*	NOT ACCEPT-ABLE	AVERAGE	ABOVE AVERAGE	VERY GOOD
A. SUBSTANTIVE KNOWLEDGE OF THE PRACTICE OF PROFESSIONAL COUNSELING AS DEMONSTRATED BY THE FOLLOWING SKILLS. • *DEPTH OF KNOWLEDGE PERTAINING TO THEORY AND ITS APPLICATION WHEN COUNSELING* • *APPRECIATION AND RESPECT FOR CULTURAL DIFFERENCES* • *CONSIDERATION OF MULTIPLE INFLUENCES ON CLIENT'S LIFE WHEN CONCEPTUALIZING CASES AND PLANNING INTERVENTIONS* • *ABILITY TO ADAPT COUNSELING METHODS AND STRATEGIES IN MANNER THAT IS SENSITIVE TO NEEDS OF CULTURALLY DIVERSE CLIENTS*	☐	☐	☐	☐
B. ABILITY TO ESTABLISH AND MAINTAIN GOOD INTERPROFESSIONAL RELATIONS AS DEMONSTRATED BY THE FOLLOWING SKILLS. • *EFFECTIVENESS IN CONSULTATION WITH MULTIDISCIPLINARY TEAMS* • *RESPECT FOR CONTRIBUTIONS OF PROFESSIONALS FROM VARIETY OF DISCIPLINES INVOLVED IN CLIENT CARE* • *DEVELOPMENT OF COLLABORATIVE RELATIONSHIPS WITH PROFESSIONALS FROM MULTIPLE DISCIPLINES*	☐	☐	☐	☐
C. POSSESSION OF EMOTIONAL MATURITY, STABILITY, AND TEMPERAMENTAL CHARACTERISTICS REQUIRED FOR PERFORMANCE AS A PROFESSIONAL COUNSELOR AS DEMONSTRATED BY THE FOLLOWING SKILLS. • *AWARENESS OF OWN BELIEFS AND VALUES AND HOW THESE HAVE AN IMPACT UPON THERAPEUTIC ALLIANCE* • *RESPECT FOR BELIEFS AND VALUES OF COLLEAGUES EVEN IF THEY ARE DIFFERENT FROM OWN BELIEFS AND VALUES* • *FLEXIBILITY AND ADAPTABILITY IN UNFORESEEN SITUATIONS* • *ACCEPTANCE OF RESPONSIBILITY FOR OWN BEHAVIORS AND HOW THESE HAVE AN IMPACT UPON OTHERS*	☐	☐	☐	☐

26. CONTINUED	NOT ACCEPT-ABLE	AVERAGE	ABOVE AVERAGE	VERY GOOD
D. UNDERSTANDING OF AND ADHERENCE TO APPROVED STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT AS DEMONSTRATED BY THE FOLLOWING SKILLS. • *DEPTH OF KNOWLEDGE AND UNDERSTANDING OF ETHICAL STANDARDS GUIDING PRACTICE FOR SUPERVISION SETTING* • *ABILITY TO ADDRESS COMPLEX ETHICAL AND/OR LEGAL ISSUES IN COUNSELING PRACTICE* • *RECOGNITION AND RESPECT FOR LIMITS TO OWN COMPETENCY* • *MAINTENANCE OF APPROPRIATE BOUNDARIES WITH CLIENTS AND COLLEAGUES*	☐	☐	☐	☐
E. PERSONAL CHARACTER AS MEASURED BY: HONESTY, INTEGRITY AND GENERAL CONDUCT AS DEMONSTRATED BY THE FOLLOWING SKILLS.	☐	☐	☐	☐
F. REPUTATION AMONG COLLEAGUES	☐	☐	☐	☐
G. CAPACITY FOR PROFESSIONAL GROWTH AND DEVELOPMENT AS DEMONSTRATED BY THE FOLLOWING SKILLS. • *MOTIVATION TO INDEPENDENTLY SEEK OUT OPPORTUNITIES FOR LEARNING* • *WILLINGNESS TO SEEK CONSULTATION WHEN FACED WITH SITUATION OUTSIDE LIMITS OF COMPETENCE, TRAINING, OR EDUCATION.* • *ABILITY TO ACCEPT, EVALUATE, AND INTEGRATE CONSTRUCTIVE FEEDBACK FROM SUPERVISORS AND COLLEAGUES*	☐	☐	☐	☐
H. I WOULD RATE THIS APPLICANT'S OVERALL PERFORMANCE UNDER MY SUPERVISION AS:	☐	☐	☐	☐
27. RECOMMENDATION FOR LICENSURE ☐ WITHOUT RESERVATION ☐ DO NOT RECOMMEND (ATTACH EXPLANATION) ☐ WITH RESERVATION (ATTACH EXPLANATION)				

IV. SUPERVISOR ATTESTATION

I have completed this application and accept full responsibility for the counseling and counseling related activities provided by the applicant for licensure. 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.

SIGNATURE	CREDENTIALS/LICENSE NUMBER	DATE

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