Division of Professional Licensing
UTAH DEPARTMENT OF COMMERCE

Clear Form

ACMHC RECORD of CLINICAL SUPERVISION

Use this form to record your clinical supervision **AFTER** obtaining licensure as an Associate level license holder.
Each Supervisor must be approved by the Division **BEFORE** you begin accruing clinical supervision hours, **NO EXCEPTIONS**.
Clinical Supervision hours may **NOT** be obtained while completing the education requirements for licensure.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Associate License Number: _____ Date Issued: _____

CLINICAL SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

Supervisor Name: _____ _____ _____
First *Middle* *Last*

Email: _____
Note: REQUIRED All Division notices and communication regarding supervision will be sent to this email.

License Type: _____ License Number: _____ State of Issue: _____
NOTE: If the supervisor listed above is licensed outside of the state of Utah an official verification of the supervisor's license, showing it is active and in good standing, must be submitted with this form.

RECORD OF CLINICAL SUPERVISION HOURS (TO BE COMPLETED BY THE SUPERVISOR)

DATES SUPERVISION COMPLETED THROUGH _____ to _____	TOTAL HOURS IN EACH CATERGORY COMPLETED UNDER THIS CLINICAL SUPERVISOR
DIRECT CLIENT CARE	
DIRECT CLINICAL SUPERVISION	
DIRECT OBSERVATION	
CLINICAL SUPERVISION (TOTAL)	

Signature of Clinical Supervisor: _____ **Date:** _____

CLINICAL SUPERVISION DEFINITIONS

Clinical Supervision Hours – 3,000 Hours or Not Less Than Two Years
Clinical Supervision Hours means work experience conducted under the supervision of a clinical supervisor, including: The practice of mental health therapy, direct client care, direct clinical supervision, direct observation, and other duties and activities completed in the course of the day-to-day job functions and work, wherein the supervisor is available for consultation with the supervisee by personal face to face contact, or direct voice contact by telephone, radio, or some other means within a reasonable time consistent with the acts and practices in which the supervisee is engaged, and **MUST** Include the Following:

Direct Client Care Hours: MUST INCLUDE the practice of mental health therapy, the utilization of patient-reported progress and outcomes to inform care, and direct observation. Hours in this category, from all supervisors, must total at least 1,200.

Direct Clinical Supervision: MUST INCLUDE the supervisee and their direct clinical supervisor meeting in real time and in accordance with the supervision contract. "Direct clinical supervision" may include group supervision of up to 2 supervisees present. Hours in this category, from all supervisors, must total at least 100.

Direct Observation: MUST INCLUDE observation of a supervisees live or recorded direct client care by the supervisee's clinical supervisor OR a license holder observer who the supervisees direct clinical supervisor approves; and after which, the supervisee and the approved license holder observer meet, in-person or electronically, to discuss the direct client care for the purpose of developing the supervisees clinical knowledge and skill. Hours in this category, from all supervisors, must total at least 25.

Group Supervision with 3 or more supervisees: NO MORE THAN 25 hours, from all supervisors, allowed in this category.

Applicant Full Legal Name: _____ _____ _____
First *Middle* *Last*

Clinical Supervisors Name: _____ License Number: _____

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CLINICAL SUPERVISOR ATTESTATION: (TO BE COMPLETED BY THE SUPERVISOR)

I certify that the applicant for licensure has successfully completed the clinical supervision, which includes direct client care, direct clinical supervision, direct observation, and may include group supervision as attested by my signature on the Record of Clinical Supervision Hours form.

I further certify that the clinical supervision provided meets the requirements outlined in Utah Code 58-60-506. During the clinical supervision period for this applicant for licensure, I approved the following license holder(s) to participate in Direct Observation:

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type**: _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type**: _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type**: _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type**: _____

I further certify that the applicant is qualified and competent to practice as a Clinical Mental Health Counselor.

Signature of Clinical Supervisor: _____ **Date**: _____

As a supervisor you are required to sign off for clinical supervision hours legally obtained by a supervised individual. However, if the supervised individual did NOT meet the expectations of clinical supervision with regard to the quality of work performed, submit a written statement regarding the performance to the Division at B8@utah.gov. All submitted statements will be reviewed by the Behavioral Health Board.

NOTE: This Supervisor Attestation must be completed by every clinical supervisor who has signed the Record of Clinical Supervision Hours Form verifying hours.