IDAHO STATE LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE & FAMILY THERAPISTS
Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
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LCPC EVALUATION AND VERIFICATION OF SUPERVISED EXPERIENCE APPLICATION

The Applicant named below is seeking licensure to practice Counseling in the State of Idaho. The Idaho Board requires the information below in order to evaluate the extent and quality of the applicant's supervised experience.

SECTION 1 - To be completed by applicant & reviewed by the named supervisor: *(this page must be submitted to Supervisor with page 2*). Please keep a copy for your records.

A. Name of Supervisor _____

B. Address Location of Supervisor _____

C. Supervisor Contact Phone Number (____)_____

D. The setting of this supervision was (mark with an X **one only and use a separate sheet for each setting**):

( ) WORK ( ) PRACTICUM ( ) INTERNSHIP

E. Hours were gained as (**check only one**): **( ) GRADUATE ( ) POST-GRADUATE**

F. Experience was earned in the following areas (mark with an X **all that apply**):

[ ] Mental Health [ ] Career Counseling [ ] Substance Abuse [ ] Marriage and Family
[ ] Gerontology [ ] School Counseling
[ ] Other. Please specify _____

G. Dates of practice by applicant at this setting: From _____ To _____

H. Total number of direct client contact hours during the period listed in G above: _____

I. Supervisor hours:

A. Total of individual face-to-face **direct** (not group) hours with supervisor during period listed in G above: _____

B. Total number of group hours with supervisor during period listed in G above: _____

C. Total number of supervisor hours during period listed in G above: _____

J. Please describe the nature of the applicant's duties:_____

_____

_____

_____

_____ _____

Print Name of Applicant Signature of Applicant

SECTION 2 - To be completed by the supervisor: (*do not complete without reviewing page 1*)

Title at time of supervision _____

Title of professional license, if held _____

State of License _____ Professional License Number _____

Area of Specialization _____

Applicant's supervised practice location (facility name and address): _____

_____

J. Please state the quality of the applicant's performance during the supervised practice period: _____

_____

_____

_____

_____

K. I have reviewed the applicant's statements. They ◯ are **or** ◯ are not substantially correct.

L. As supervisor, do you have any reservations about the applicant being granted a license? ◯ YES ◯ NO

IF **YES**, PLEASE SPECIFY (Attach additional sheet if necessary):

AFFIDAVIT

I hereby certify under penalty of perjury that the responses provided by both the applicant and myself are true and accurate to the best of my knowledge and belief, and that I may be required to provide additional information. I further certify that I have reviewed and will comply with the Idaho Laws and Rules, including the adopted Code of Ethics, governing supervision and the practice of Counseling and/or Marriage & Family Therapy.

_____ _____

Printed Name of Supervisor Signature of Supervisor

NOTICE TO SUPERVISOR

Please seal BOTH PAGES of this completed document in an envelope, sign your name across the sealed back flap, and return it to the applicant. Please be aware this document will become part of the applicant's file and the applicant has the right to request anything from the file.