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
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: cou@dopl.idaho.gov

LPC COUNSELOR 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 section 2)*****. Please keep a copy for your records. DO NOT submit supervision logs unless requested.**

A. Name of Supervisor _____

B. Address, City, State of Supervision_____

C. Supervisor Contact Phone Number (_____)_____

D. The setting of this supervision was (**check 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 area (**check one only and use a separate sheet for each setting**):

☐ **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 supervised practice clock hours during period listed in G above (includes direct and indirect): _____

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

J. Supervisor hours:

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

K. 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*)

SUPERVISOR INFORMATION

Supervisor 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):

_____

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

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

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.

_____ _____

Print Name of Supervisor Signature of Supervisor

NOTICE TO SUPERVISOR

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.

To accept all reported hours of supervised experience as valid, these forms may be submitted using the following methods:

SCAN AND EMAIL – The supervisor signing these forms may scan and email them to cou@dopl.idaho.gov. If the license applicant is scanning and emailing the documents, please ensure that the signing supervisor is cc'd on the email submission.

MAILING YOUR DOCUMENTS - 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.