

Section II: To be Completed by the Supervisor (continued)

2 ADDITIONAL QUALIFYING CRITERIA: (Complete all that apply for your profession)

Licensed Psychologist:

a. ABPP Diplomate In: Counseling Clinical School

Year received _____

b. Doctorate in clinical or counseling or school psychology? Yes No

If "yes," was it from a program which was New York State registered or APA approved? Yes No

c. Did you complete a formal internship which included psychotherapy training? Yes No

If yes, name of program: _____ Date completed: _____ / _____ / _____
mo. day yr.

Was the internship accredited by the APA at that time? Yes No

d. If your doctorate was in a field other than clinical or counseling or school psychology, did you take a formal respecialization program in clinical or counseling or school psychology? Yes No

If yes, name of program: _____ Date completed: _____ / _____ / _____
mo. day yr.

Physicians:

Have you completed a psychiatric residency? Yes No

If yes, name of program: _____ Date completed: _____ / _____ / _____
mo. day yr.

LCSW:

A qualified supervisor must have at least three years of full-time, post-MSW supervised experience in **diagnosis and psychotherapy**, prior to supervising the applicant. Full-time experience is defined as 20 client contact hours (45-minute sessions) of diagnosis, psychotherapy and assessment-based treatment planning each week for 36 months. Part-time experience of 10 or more client contact hours per week will be accepted up to 72 months. You must have received four hours per month of in-person supervision and at least two hours each month must be individual clinical supervision by a qualified supervisor (LCSW, psychologist or psychiatrist).

Please note that other direct practice with clients does not qualify under New York State Law. In order to determine if you are qualified to supervise, we must have the following information to evaluate your post-degree supervised experience in diagnosis and psychotherapy.

Dates of Post-MSW Experience	Weekly Client Contact Hours	Hours of Individual Supervision/Month	Hours of Group Supervision/Month	Supervisor Name	Supervisor License and Jurisdiction

Have you earned the "R" Psychotherapy Privilege? Yes No Date conferred: _____ / _____ / _____
mo. day yr.

All Supervisors:

Have you completed a prescribed postgraduate program in psychotherapy in an institute **chartered by the New York State Board of Regents** or one in another jurisdiction, which might be considered equivalent as determined by the State Board? Yes No

If yes, name of Institute: _____

Date completed: _____ / _____ / _____
mo. day yr.

Attach a copy of license and Curriculum Vitae.

Section II: To be Completed by the Supervisor (continued)

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise experience for the LCSW Psychotherapy "R" Privilege. I understand that the above information will be used to determine my eligibility as a supervisor of LCSWs seeking the psychotherapy "R" Privileges under New York State Insurance Law and that the answers given are truthful and accurate to the best of my ability.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name : _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

If the supervisor is not an employee of the same agency as the applicant, please provide information about the applicant's employer:

Name of Agency/Employer: _____
(Where supervised experience took place)

Agency Address: _____

Phone: _____ Fax: _____

E-mail: _____

The patient will be notified that the agency has authorized a third-party supervisor with access to the patient's records.

Name of Agency Representative: _____

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
Month Day Year

Notary Stamp

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Social Work Unit, 89 Washington Avenue, Albany, NY 12234-1000