CLINICAL SUPERVISION AGREEMENT

PURPOSE OF AGREEMENT:

By signing this agreement, we agree to enter into a clinical supervision experience together and have discussed a number of issues that provide a context for the experience. The purpose of this agreement is to outline those issues and to serve as a resource for working together.

TERMS OF SUPERVISION:

The terms of this clinical supervision agreement between _____ (Supervisor) and _____ (Supervisee) begin on this day of _____ and continue until consent is terminated in writing by above participants. We have agreed to commit _____ hours per month of individual, dyadic, or group supervision. We have decided to use this time together to staff clinical cases, discuss possible counter-transference, review therapeutic orientations and interventions, and engage in other discussions that will further the Supervisee's professional and clinical development.

If you are unable to attend a supervision session, you are asked to give 24-hour notice. In the event that either supervisor or supervisee is ill, every attempt will be made to notify as soon as possible and supervision will be rescheduled.

CONSENT AND CONFIDENTIALITY:

Verbal informed consent must be obtained from clients who will be reviewed in our supervision sessions. You are required to notify clients that you are receiving supervision and provide clients with your supervisor's credentials. All client information and data will be handled with the utmost care and confidentiality in accordance with HIPAA laws and the code of ethics specific to my professional license.

Regarding the confidentiality of our supervisory relationship, I will not disclose our agreement to work together to anyone else. However, you are welcome to disclose our supervisory relationship to anyone you would like. Similarly, in an effort to protect and respect your privacy, I do not engage or connect with supervisees through social media, with the exception of LinkedIn.

LIABILITY INSURANCE:

Professional liability insurance is maintained by both the Clinical Supervisor and the Supervisee. The Supervisee will provide documentation of insurance coverage before supervision begins.

CLIENT EMERGENCIES:

In the event that a client is in imminent danger (threat of homicide or suicide) call 911 and/or your state's Crisis Emergency Line immediately.

In the event of child/elder/dependent adult abuse and/or neglect, contact your state's reporting line immediately and within 24 hours. Also, inform your primary Clinical Supervisor and any other appropriate individual in your agency of employment. If unable to reach your Clinical Supervisor, leave a confidential voicemail and contact the next agreed upon person to call in such cases. Name and contact number of primary and secondary contact:

Primary Emergency Contact Name:	
Primary Emergency Contact Phone:	
Secondary Emergency Contact Name:	
Secondary Emergency Contact Phone:	

USE OF TECHNOLOGY ASSISTED SERVICES IN SUPERVISION:

Currently, I use a tele-supervision platform called Motivo for all remote sessions. Motivo utilizes a third party video software which is HIPAA-compliant and includes end-to-end encryption.

If our supervision occurs online, I ask that you determine who has access to your computer and electronic information from your location. I encourage you to only communicate through a computer that you know is safe i.e. wherein confidentiality can be ensured.

If we are scheduled for a tele-supervision session and we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within ten minutes. If reconnection is not possible, contact me to schedule a new session time.

Please be aware of the following practices regarding my use of technology to provide supervision:

- Text messaging via cell phone is acceptable to arrange sessions and for housekeeping issues only. Please do not disclose identifying information about a client over text message.
- If you call me, please be aware that unless we are both on landline phones, the conversation is not confidential.
- I prefer using email only to arrange or modify supervision sessions, to communicate about housekeeping duties such as signing supervisory forms or to share resources and interventions with one another. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider.

Please understand that tele-supervision is not appropriate if you and/or your client are experiencing a crisis. As stated previously, if a life-threatening crisis should occur, you agree to contact a crisis hotline or call 911.

Please be advised that I follow the laws and professional regulations of the State of _____ with regards to technology-assisted clinical services. **However, it is the sole responsibility of you, the supervisee, to determine if my license, training credentials, and method of supervision delivery meet the requirements for clinical supervision in the state where you are seeking licensure**. I am happy to provide you with any information necessary to help you determine if I meet these state-specific requirements.

STRUCTURE OF SUPERVISION:

My supervision style stems from _____. We will implement elements of several approaches, including _____ _____ to our clinical supervision sessions, with a concentration on professional development and ethical conduct. All supervision sessions will be conducted in an atmosphere of open communication and mutual respect. Should any dissonance or disagreements arise, they will be handled in the same manner. You agree to come prepared to discuss pertinent cases concerns to each supervision session and will exhibit openness to discussing issues surrounding your own clinical development.

It is not my intention to delve into any personal issues that may be influencing your professional development. I ask that you let me know immediately if you feel I am crossing any personal boundaries. However, you may wish to consider individual therapy to address any personal issues that are affecting your ability to be objective with your clients. One's own therapeutic process, I believe, is essential to fully understand the perspective of the client. If at any point you need a referral to a counselor for personal reasons, I will provide you with that information.

As part of my supervisory responsibilities, I will sign off on all your hours and fill out the necessary recommendation forms from state or credentialing bodies, provided those bodies have agreed upon our supervisory plan.

IDENTIFICATION OF GOALS:

We have identified the following goals for our work together:

- _____
- _____
- _____
- _____

Your signature below indicates that you have read this supervision agreement. By signing this consent you also agree to abide by the ethical codes of your credentialing body or state board.

_____ _____

Supervisee Signature Supervisor Signature

_____ _____

Date Date

SUPERVISOR INFORMATION:	
Full Name:	
Credentials:	
Supervisory Credentials:	
Licensure State:	
License Number:	
License Issue Date:	
License Expiration Date:	
Contact Number:	
Contact Email:	