

**FORM B**

**ALABAMA STATE BOARD OF SOCIAL WORKER EXAMINERS**  
**Clinical Supervision Plan**

**\*\*\*Be sure to complete ALL portions of this form. Do not submit if incomplete.\*\*\***

Please provide the information requested below and submit this form with a copy of the supervisee's Job Description.

**I. Supervisee Information (LMSW)**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Is supervision related to the clients from this business? ☐ Yes ☐ No  
Work schedule: ☐ Full time (30hrs/wk) or more ☐ Part time (Hours per week \_\_\_\_\_)

**II. Board-approved Supervisor Information**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Are you a board-approved supervisor? ☐ Yes ☐ No

**III. Clinical Supervision Schedule**

Practice Location Name \_\_\_\_\_

Practice Location Address \_\_\_\_\_

Will supervised experience be accrued at multiple locations? Yes ☐ No ☐ (If yes include a separate list of site names and addresses)

Beginning Date of Supervision: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) **Supervision may begin up to 30 days before the plan is submitted for approval. The board office shall approve a start date no more than 30 days prior to the board's receipt of the plan. If board-approval is not granted, no experience credit can be gained.)**

Supervision Format: ☐ Individual ☐ Combination of Individual and Group

Supervision Sessions per Month: \_\_\_\_Hours Individual + \_\_\_\_Hours Group = \_\_\_\_Total Hours/Month

The following statements must be initialed by the supervisor:

\_\_\_\_\_ Through my guidance the supervisee will maintain client confidentiality by following the appropriate statutes, rules, and guidelines (including HIPPA and any other applicable laws).

\_\_\_\_\_ The strategies and methods of supervision I employ will be formulated to meet the professional growth needs of the supervisee.

\_\_\_\_\_ I will keep legible, accurate, complete, signed supervision notes indicating the content, duration, and date of supervision as well as the hours worked by the supervisee.

#### **IV. Supervision Process (Attach extra pages if necessary)**

Describe the supervisee's work setting(s):

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Describe the clients served:

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Describe the supervisee's duties and responsibilities including treatment methods utilized:

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Formulate four goals for the supervision:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Methods of supervision to be used:

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#### **IV. Attachments to Include**

- ☐ Official Job Description on agency letterhead (Official job description must reflect those duties are clinical as defined in applicable rules)
- ☐ If supervision of agency-based clients is done with a supervisor who practices outside of the employment setting and is not under contract with the employer to provide supervision, a letter from the employer on letterhead approving the outside supervision with the specific supervisor must be attached.

#### **V. Affidavit of Understanding and Signatures**

I hereby certify that I have reviewed Chapter 850-X-03 of the Alabama Administrative Code and am familiar with the regulations pertaining to supervision in the state of Alabama. I understand that I must observe and comply with the supervision guidelines set forth in the rules.

I am aware that the Alabama State Board of Social Work Examiners will conduct random audits to ensure compliance with supervision requirements.

**A photocopy of this submission has been provided to the supervisee.**

**A photocopy of this submission has been placed in the supervision file maintained by the supervisor.**

Under penalties of perjury, I declare and affirm that the statements made in the supervision plan, including accompanying statements, are true, complete, and correct. I understand that any false or misleading information in, or in connection with my supervision plan may be cause for denial or loss supervision time received and/or loss of licensure. **(Supervision may begin up to 30 days before the plan is submitted for approval. If approval is not granted, no creditable experience can be gained.)**

Supervisee Signature \_\_\_\_\_ Date \_\_\_\_\_  
Supervisee Name \_\_\_\_\_  
Printed \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_  
Supervisor Name \_\_\_\_\_  
Printed \_\_\_\_\_

Submit to:  
Alabama State Board of Social Worker Examiners  
P.O. Box 301620  
Montgomery, Alabama 36130

Keep This Page for Reference

Overview of some important supervision requirements:

- Supervisory sessions may be in one-on-one sessions or in a combination of individual and group sessions. There can be no more than six individuals in a supervision group.
- There shall be:
  - (i) no fewer than four hours of supervision each calendar month;
  - (ii) no more than 10 hours of supervision during a calendar month.

Important information:

- Submission of a Clinical Supervision Plan and form does not ensure acceptance of the plan by the board. Acceptance is verified by a letter mailed to the supervisee at the mailing address on file with the board.
- A separate Clinical Supervision Plan and form *must be submitted* to the board for approval for *each supervisor providing supervision*. Similarly, upon cessation of supervision, a separate Clinical Supervision Verification Form must be submitted for each board-approved Clinical Supervision Plan in effect.
- Submission of a Clinical Supervision Verification Form does *not* ensure that the board will accept the verification of supervised experience *as submitted*. The Verification Form must be submitted *within 30 days* of completion of the supervision and must meet all criteria required by the board.
- If the board approves the Clinical Supervision Plan, the supervisor and supervisee will receive a written confirmation in the mail. If a written confirmation is not received, then the plan is not approved.
- **The board will conduct random audits of supervision plans to ensure compliance to supervision rules.**