

**REGISTERED INTERN SIX-MONTH
SUPERVISOR EVALUATION & HOURS REPORT**

Registered Intern: _____ OBLPCT Registration #: _____

Six-Month Reporting Period: _____ through _____
Month/Year Month/Year

Supervisor: _____

SUPERVISOR EVALUATION

Yes No

What theory base or therapy underlies the intern's practice?

Is the intern gaining experience assessing, diagnosing and treating clients with mental health disorders?

If not, please describe plans to ensure intern gains this required experience.

Is the Intern distributing a Professional Disclosure Statement to each client at onset of counseling?

Does the Intern understand Oregon's laws and rules regulating LPCs and LMFTs?

Do you routinely discuss the above with emphasis on the Board's Code of Ethics?

Please evaluate the intern's strengths and the need for improvement in any area.

Please describe the Intern's professional growth during the last six months.

Please describe the Intern's goals for gaining clinical hours and professional growth during the next six months.

Do you have any concerns about licensing this Intern? If so, please describe the concerns.

Is this Intern competent and addressing the needs of his or her clients?

Comments:

REPORTED HOURS

Report # _____

DATES	DIRECT CLIENT CONTACT HOURS		SUPERVISION HOURS			
	(A) Total Direct Client Contact Hours, including telephone & electronic media	(B) LMFT Interns Couples & Family*	(C) Total Individual Supervision	(D) Electronic**	(E) Total Group Supervision	(C + E) SUPERVISION TOTAL
EXAMPLE: May, 2001	42	12	2		1.5	3.5
TOTAL						

*Number of Reportable Couples and Family hours (LMFT Only)

**Number of Individual Hours of Electronic Supervision

SIGNATURES

Supervisor 1

Email address

Date:

Supervisor 2

Email address

Date:

Intern

Email address

Date:

OFFICE USE ONLY	
Notes: _____	

Evaluator _____	Date _____ Approved Hours _____