



Counselor, Social Worker & Marriage and Family Therapist Board

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Columbus, Ohio 43215-5919

614-466-0912 & Fax 614-728-7790

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CLINICAL FIELD EVALUATION & VERIFICATION OF SUPERVISED EXPERIENCE

PLEASE READ CAREFULLY! - Refer to paragraph (A) of rule 4757-13-03 for more detail

Instructions to Clinical Resident: forms required after 1,500 and 3,000 hours (full two years).

1. All supervised experience for licensure must be documented by the person(s) who supervised you.
2. Complete Part A, and sign the Waiver and Liability before giving this form to your supervisor.
3. You must provide each supervisor with a business-size envelope, which he/she can return to you and you can forward to the board. The form must arrive at the board intact.
4. We will confirm all evaluation and verification forms in our possession after you have successfully passed the exam.

Part A: To be Completed by the Clinical Resident

1. Name:			No SSN required	
2. Street Address:		City:	State:	Zip:
3. Daytime Phone:		Email:		County:
4. License #:	License Issue Date:		Expiration Date:	
5. Name of Supervisor:			Title:	
Name and Address of facility where clinical work and supervision took place:				
7. Dates of Supervision at this setting: From: _____ To: _____ <div style="text-align: center; margin-left: 100px;">DD/MM/YY DD/MM/YY</div>				
Total number of hours: Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Total work hours at site: _____				
Total number of face-to-face supervisory hours: _____				
Waiver of Liability				
I _____ (applicant) hereby authorize _____ (supervisor)				
to provide the Counselor Professional Standards Committee of The State of Ohio Counselor, Social Worker and Marriage & Family Therapist Board with all information the committee may deem relevant to my qualifications as an applicant. I hereby release and discharge the supervisor from all claims out of the provision of such information.				
Signature _____ Date _____				

Instructions to Supervisor: Remember - A board approved supervisor shall not supervise more than six supervisees who are registered at one time with this board.

1. Complete Part B ONLY if the waiver has been signed by the applicant.
2. You must have your signature **Notarized**.
3. After completing this form, seal it in a business size envelope, sign across the seal, and return the envelope to the applicant.

NOTE: The Board assumes that you are willing to interpret or substantiate your recommendation if necessary.

PART B: To be Completed by Supervisor

1. Does scope of practice include diagnosis and treatment of mental and emotional disorders? Yes No
2. Does the candidate's scope of practice include 50% of time spent diagnosing and treating? Yes No

3. Type of professional license held: _____

State: _____ License Number: _____

4. List your area(s) of professional competence:

5. Please describe the activities supervised:

6. Do you recommend the applicant for licensure: Yes, Without Reservation No (if no, please explain) Additional Explanation/Comments (attach separate sheet if necessary):

7.) PLEASE RATE THE APPLICANT ON THE FOLLOWING CLINICAL SKILLS AND ABILITIES. THE FOLLOWING KEY IS RECOMMENDED WHEN ASSESSING THE APPLICANT'S LEVEL OF COMPETENCE:

5	High:	<i>The applicant performs extremely well in this area.</i>
4	High Average:	<i>The applicant's performance level is more than adequate in this area.</i>
3	Average:	<i>The applicant possesses adequate competence in this area.</i>
2	Low Average:	<i>The applicant clearly lacks competence in this area.</i>
1	Low:	<i>The applicant clearly lacks competence in this area.</i>
N/O	No Opportunity to Assess:	<i>The rater has not had the opportunity to observe the applicant's performance in this area.</i>

SKILLS AND ABILITIES**ASSESSMENT**

A clinical counselor must demonstrate acceptable levels of performance in:

HIGH		AVERAGE		LOW		N/O
5	4	3	2	1		

CLINICAL PSYCHOPATHOLOGY, PERSONALITY AND ABNORMAL BEHAVIOR

1.) Knowledge of specific personality theories and their application in mental health work.						
2.) Understanding basic concepts of normal and abnormal behavior.						
3.) Recognizing the levels of severity of abnormal behaviors.						
4.) Understanding the life cycle of normal growth and development from infancy to maturity and old age.						
5.) Understanding the impact of diverse cultures, ethnic and economic background on personality development.						

EVALUATION OF MENTAL AND EMOTIONAL STATUS

6.) Knowing the names and uses of the various assessment measures.						
7.) Using behavioral observation, social history and intake Questionnaires as appraisal techniques.						
8.) Using assessment procedures in diagnosis, treatment planning, and the conduct of mental health treatment.						
9.) Using and interpreting group and individual standardized tests of mental ability, interests aptitude, personality, and achievement.						
10.) Knowing under what conditions, and by whom specialized tests may be administered (i.e. physical and neurological examinations, mental status examinations, EEG. Etc...)						

DIAGNOSIS OF MENTAL AND EMOTIONAL DISORDERS

11.) Knowing the signs and symptoms of psychosis, personality disorders and neuroses.						
12.) Using the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) in making a diagnosis.						
13.) Conducting mental status examinations.						
14.) Knowing the psychopathologic conditions related to children, adolescents, young and mid-life adults and the aged.						
15.) Knowing the behaviors, natural history, and psychodynamics of special problems such as mental retardation, psychosexual disorders, substance abuse, and addiction.						

SKILLS AND ABILITIES**ASSESSMENT****A clinical counselor must demonstrate acceptable levels of performance in:**

HIGH		AVERAGE		LOW		N/O
5	4	3	2	1		

METHODS OF INTERVENTION AND PREVENTION OF MENTAL AND EMOTIONAL DISORDERS

16.)	Using generic counseling skills, i.e. attending, responding, goal setting, feedback, summarization.						
17.)	Knowing the rationale, process and limitations of the psychological methods of intervention i.e. client-centered, psychological hypnotherapy, psychotherapy, etc.						
18.)	Knowing the method of educational models of intervention i.e. rational emotive therapy, reality therapy, psycho-social rehabilitation, etc.						
19.)	Using different kinds of intervention strategies in different situations. i.e. marriage and family, crisis situations, child abuse, etc.						
20.)	Using specialized intervention strategies in/with diverse populations i.e. minorities, children, substance abusers, psychiatric clients, terminally ill, etc.						

TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

21.)	Developing and implementing a treatment plan.						
22.)	Reporting and assessing progress of treatment.						
23.)	Knowing the legal and ethical issues involved in treatment.						
24.)	Making appropriate and successful referrals of clients.						
25.)	Understanding the use of mood altering chemical agents in the treatment of mental and emotional disorders.						

AFFIDAVIT: I hereby attest that all the information on this form is true and correct to the best of my knowledge. I AM WILLING TO ANSWER ADDITIONAL QUESTIONS CONCERNING THIS EVALUATION IF THE BOARD DEEMS IT NECESSAARY.

Name of the applicant (print clearly)

Name of Evaluator (print clearly)

Signature of Evaluator

Date

State of _____

County of _____

The undersigned, being duly sworn, deposes and says that he/she is the person who executed this evaluation, that the statements, herein, are true, that he/she has not suppressed any information that might affect this evaluation, and that he/she has read and understands this affidavit.

Signature of Evaluator _____

Signature of Notary Public _____

Subscribed and sworn to before me, this _____ day of _____ 20____

My commission expires: _____

This form must be signed and mailed by the evaluator within (15) days of completion of the supervised period to the address shown on the front of this form.