

Professional Supervision Agreement For Associate Level Treatment Providers and/or Evaluators: *Adult and Juvenile Applicants*

You may copy this page.

Applicants Name: _____
Date: _____

Supervisor's Name: _____
Agency: _____
Address: _____
City, State, Zip _____
Telephone: _____
Fax: _____ Email: _____

Please note, supervision shall not be provided by a relative of the applicant.

I, _____ do hereby verify that I have provided _____ hours
(Supervisor) (#)
of face-to-face supervision to the above named applicant. I have provided _____ hours
(#)
of face-to-face co-therapy in the same room. These hours were accumulated in accordance with the
Standards and were provided at: _____

(Agency Name)

In signing this agreement, we verify that we will accumulate the required supervisory hours as prescribed in the Standards. This supervision will consist of approximately _____ hours a month of supervision directly related to sex offense specific treatment/evaluation and will include the following types of supervision (*please specify activities*): _____

Supervisor's signature _____ Date _____

Applicant's signature _____ Date _____