Behavioral Health Services
Authority and Quality Improvement Services

Clinical Supervision Reporting Form

Form Type

☐ NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to AQIS.

Registered/Waivered Supervisee Information (select all that apply)

☐ County Employee
or
☐ Contract Employee

☐ Adult and Older Adult Behavioral Health Services [AOABH]
☐ Children and Youth Prevention Behavioral Health Services [CYPBH]
☐ Drug Medi-Cal Organized Delivery System [DMC-ODS]

Name:

Registration Type: Registration #:

DHCS Professional Licensing Waiver [Registered/Waivered Psychologist ONLY] ☐ YES ☐ NO IF YES, THE DHCS PROFESSIONAL LICENSING WAIVER FORM IS REQUIRED TO BE SUBMITTED TO MCST.

Phone: Email:

Program/Clinic:

Service Chief/Program Director:

Clinical Supervisor Information

Name:

License Type: License #:

Phone: Email:

Program/Clinic:

Service Chief/Program Director:

Supervision Term

Start Date: End Date:

If terminating clinical supervision, complete this section:

Reason for termination:

- If changing clinical supervisor, additionally submit required document(s) for new clinical supervisor
- If licensed, date of promotion per HR:
- If terminating employment, date of termination:
- If other, please specify:

License type	While accruing hours	After required hours have been accrued
LCSW/LMFT/LPCC	At least 1 hour of direct supervisor contact each week for which experience is credited in each setting. 1 additional hour of direct supervisor contact is required for 10+ hours of direct clinical counseling in a week in any setting.	A minimum of 1 hour of direct supervisor contact per week for each work setting.
PSYCHOLOGIST	At least 1 hour of direct individual supervision each week. Must be provided with supervision for 10% of the total time worked each week.	Supervision is still required until licensed.

*For more detailed requirements, please refer to respective Boards.

I certify that I understand the responsibilities regarding clinical supervision and that the clinical supervision provided meets the requirements as specified by the Board. I attest that the information submitted on this form is true and correct:

Registered/Waivered Supervisee Signature | Date

Licensed Clinical Supervisor Signature | Date

*Please complete in full and submit to: AQISManagedCare@ochca.com. For questions, please contact AQIS main line: 714-834-5601.