Mental Health and Recovery Services
Quality Management Services

Clinical Supervision Reporting Form

Form Type

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

Registered/Waivered Supervisee Information (select all that apply)

☐ County Employee
Or
☐ Contract Employee

☐ Individual Supervision
☐ Group Supervision
☐ Both- 2 CSRFs, if 2 different supervisors

☐ Adult and Older Adult [AOA]
☐ Children and Youth Prevention [CYP]
☐ Drug Medi-Cal Organized Delivery System [DMC-ODS]

Name:

Registration Type: Select Registration

Registration #

IF Registered/Waivered Psychologist, 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:

ARE YOU, PROVIDING SUPERVISION FOR A SUPERVISEE OUTSIDE OF YOUR EMPLOYER?
IF YES, SUBMIT THE WRITTEN OVERSIGHT AGREEMENT. ☐ YES ☐ NO

License Type: Select 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: ☐ Licensed ☐ Change of Supervisor ☐ Termination of Employment ☐ Other

- 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:

CHECKLIST OF DOCUMENTS REQUIRED TO SUBMIT TO MCST:

☐ BBS Supervisor Self-Assessment Report Form
☐ BBS Written Oversight Agreement (if applicable)
☐ BBS or BOP Supervision Agreement Form
☐ DHCS Mental Health Professional Licensing Waiver (Psychologist only)
☐ BBS Live-Scan Service Form-BBS 90 Day Rule (Contracted Only)
☐ 2 CSRFs, if there are multiple supervisors (i.e. group & individual)
☐ Clinical Supervisor Agreement Form (County Only)

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 QMS main line: 714-834-5601.

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Clinical Supervisor Information

Date:

Name of Primary Clinical Supervisor:

List of All Current Supervisees

Name(s) of Current Supervisee(s)	Type of Supervision	Program Name	Supervisee Classification
Example: Jane Doe	☒ Group ☐ Individual	AOA: Anaheim Clinic	ASW
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		

***** Reminder: If clinical supervision is terminated for any reason, a CSRF with the end date is required.**

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