Behavioral Health Services: Quality Management Services

Clinical Supervision Reporting Form

STATUS UPDATE:

☐ NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.)

☐ County Employee
☐ Contract Employee

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

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

ClinicalTrainee: *An unlicensed individual who is enrolled in a post-secondary educational degree program that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship or internship approved by the individual's program; and meets all relevant requirements of the program and /or applicable licensing board to participate in the practicum, clerkship or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.*

SUPERVISEE INFORMATION:

Supervisee Name:
NPI #:
Phone:
Registration Type: Select Type
Registration #: (if applicable)
Other:
Email:
Program:
Service Chief/Program Director:

CLINICAL SUPERVISOR INFORMATION:

Name:
NPI #:
License Type: License Type
License #:
Phone:
Email:
Program:
Service Chief/ Program Director:

SUPERVISION TERM:

Start Date:
End Date:

REASON FOR TERMINATING CLINICAL SUPERVISION:

☐ Termination of Employment (enter date of separation):
☐ Change of Supervisor
☐ Became Licensed (enter date of license):
☐ Other, please specify:

CHECKLIST OF DOCUMENTS REQUIRED TO SUBMIT TO MCST:

☐ BBS Supervisor Self-Assessment Report Form BBS
☐ BBS Written Oversight Agreement (if applicable)
☐ BBS or BOP Supervision Agreement Form
☐ DHCS Mental Health Professional Licensing Waiver (Psychologist only)
☐ BBS Live-Scan Services 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: BHPSupervisionForms@ochca.com. For questions, please contact QMS main line: 714-834-5601.

Behavioral Health Services
Quality Management Services

Clinical Supervision Reporting Form

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		
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	☐ Group ☐ Individual		
	☐ Group ☐ Individual		

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

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