

Board of Behavioral Sciences

1625 North Market Blvd., Suite S200, Sacramento, CA 95834

Telephone: (916) 574-7830

www.bbs.ca.gov**SUPERVISORY PLAN FOR LMFT SUPERVISEES**

This form is required for supervisory relationships established with AMFTs and MFT Trainees PRIOR TO January 1, 2022 IF they are continuing past January 1, 2022

A licensed mental health professional who provides supervision to any person gaining experience toward LMFT licensure is required by law to complete and sign a *Supervisory Plan* as described below:

- For supervisory relationships that were established PRIOR TO January 1, 2022, IF they are continuing past January 1, 2022:

Complete this *Supervisory Plan for LMFT Supervisees*. Do NOT submit it to the Board. The supervisor and supervisee shall retain it for their records.

- For supervisory relationships established ON OR AFTER January 1, 2022 (for all types of supervisees):

Use the *Supervisory Plan* form that is contained within the required [Supervision Agreement](#).

SUPERVISEE'S INFORMATION

Supervisee's Name: Last	First	Middle
Date Supervisory Relationship Established:		
SUPERVISEE'S CURRENT STATUS (<i>as of the date this plan is signed</i>):		
<input type="checkbox"/> MFT Trainee <input type="checkbox"/> AMFT		
<input type="checkbox"/> AMFT Applicant: Date applied: _____ BBS File No. (if known): _____		
<input type="checkbox"/> Registered AMFT Number: _____ Date Issued: _____		

SUPERVISOR'S INFORMATION

Supervisor's Name: Last	First	Middle
License Type: <input type="checkbox"/> LMFT <input type="checkbox"/> LCSW <input type="checkbox"/> LPCC <input type="checkbox"/> LEP <input type="checkbox"/> Licensed Clinical Psychologist <input type="checkbox"/> Physician Board-Certified in Psychiatry by the American Board of Psychiatry and Neurology		
California License Number:	Date Issued:	Expiration Date:

Supervisor's Name: Last	First	Middle
Supervisee's Name: Last	First	Middle

Supervisory Plan

The supervisor and supervisee are required by law to collaboratively develop a supervisory plan that describes the goals and objectives of supervision. *If you are not the supervisee's primary supervisor, you may either develop a separate plan or use the same plan as the primary supervisor. Attach additional pages if needed.*

DESCRIBE THE GOALS AND OBJECTIVES OF SUPERVISION BELOW:

Supervisor's Name: Last	First	Middle
Supervisee's Name: Last	First	Middle

Supervisory Plan (continued)

By signing below, I acknowledge that this Supervisory Plan was developed collaboratively with the supervisee. I also understand that I am required to do all of the following:

1. Complete an assessment of the ongoing strengths and limitations of the supervisee at least once a year and at the completion or termination of supervision, and provide a copy to the supervisee.
2. Ensure that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee.
3. Monitor and evaluate assessment, diagnosis, and treatment decisions of the supervisee and provide regular feedback.
4. Monitor and evaluate the ability of the supervisee to provide services at the site(s) where the supervisee will be practicing and to the particular clientele being served.
5. Monitoring and addressing clinical dynamics, including, but not limited to, countertransference, intrapsychic-, interpersonal-, or trauma-related issues that may affect the supervisory or practitioner-patient relationship.
6. Review progress notes, process notes, and other treatment records.
7. Directly observe therapy, or review audio or video recordings of therapy, in an amount I deem appropriate, with the client's written consent.

Supervisor's Signature

Date signed

By signing below, I acknowledge that this Supervisory Plan was developed collaboratively with my supervisor.

Supervisee's Signature

Date signed
