PRE-MASTERS INTERNSHIP FORM

Name of Applicant: ____

INSTRUCTIONS**: Please duplicate this form as necessary. See following page for the definition of Approved Supervisor.** ***PLEASE PRINT CLEARLY OR TYPE. DO NOT ALTER THE FORM IN ANY MANNER. Forms with white-out, cross-out or copies will not be accepted.***

MINIMUM REQUIREMENTS**: A distinctly defined, post-Practicum, supervised curricular experience that totals a minimum of 600 clock hours, which must include:**

(1) 240 contact hours of Direct Client Contact Experience in Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice defined under 262 CMR 2.02; and,

(2) 45 Supervisory Contact Hours of supervision with:

- **(a) A minimum of 15 Supervisory Contact Hours of Individual Supervision;**
- **(b) A minimum of 15 Supervisory Contact Hours of Group Supervision, with no more than ten supervisees in group.**
- **(c) The remaining 15 supervisory contact hours may be either Individual or Group Supervision.**

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 75 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) by a Licensed Mental Health Counselor or an equivalently Licensed Mental Health Counselor from another state or jurisdiction.**

Remainder of Form to be completed by Approved Supervisor

Name of Supervisor: ____
Supervisor's Title: ____
Supervisor's License Type and Number:____
Supervisor's Graduation year: _______________________
Supervisor's phone number: _________________________

Name/Address of Clinical Facility: ____
____

Dates of Supervision of the Applicant: From:____/____/______To:___/_____/______(month/date/year)

The applicant worked _____ hours per week for _____weeks for a total of __________MH experience hours

Number of direct, face-to-face, clinical contact experience hours completed during this period: _______

Number of supervisory contact hours provided during this period by this supervisor:
Individual: _________ Group: _________

Has any disciplinary action been taken against you by any of the following (if yes, please submit detailed explanation):

<u>Professional Association or Organization</u>:	**Yes: ____**	**No: ____**
<u>Governmental Authority (e.g. Professional Licensing Board)</u>:	**Yes: ____**	**No: ____**
<u>Third Party Insurance Carrier:</u>	**Yes: ____**	**No: ____**
<u>Credentialing Board:</u>	**Yes: ____**	**No: ____**

I have read the definitions of Approved Supervisor listed in 262 CMR and/or below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

____

Signature of Approved Supervisor **Date**

<u>Definition of an Approved Supervisor (Post-June 5, 2015):</u>

An approved supervisor is a practitioner with three years of Full Time or the equivalent Part Time post-licensure clinical Mental Health Counseling experience who is also either:

(a) a Massachusetts Licensed Mental Health Counselor;

(b) a Massachusetts licensed independent clinical social worker;

(c) a Massachusetts licensed marriage and family therapist;

(d) a Massachusetts licensed psychologist with Health Services Provider Certification;

(e) a Massachusetts licensed physician with a sub-specialization in psychiatry;

(f) a Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or,

(g) where practice and supervision occur outside of the Commonwealth, an individual who is an independently licensed mental health practitioner with a license or registration equivalent to on listed under 262 CMR 2.02(a)-(f).

I have read the definitions of Approved Supervisor, which were in effect prior to June 5, 2015 as listed below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

____

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Pre-June 5, 2015):

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(b) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:
1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:
1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

3. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
4. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license:

______________________________________ *LICENSE/CERTIFICATE #* ______________________

OUT OF STATE SUPERVISOR: Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # __________ State________ Licensure type____

APPLICANT'S NAME: ____