

PRE-MASTERS PRACTICUM 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.

MINIMUM REQUIREMENTS: A seven week period at the academic campus or Clinical Field Experience Site in which the applicant accrued 100 clock hours, which includes:

- (1) 40 contact hours of Direct Client Contact Experience in Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice as defined under 262 CMR 2.02 or peer role plays and laboratory experience in individual, group, couple and family interactions; and,
- (2) 25 supervisory contact hours of supervision with:
  - (a) A minimum of 10 Supervisory Contact Hours of Individual Supervision;
  - (b) A minimum of 5 Supervisory Contact Hours of Group Supervision, with no more than ten supervisees in group; and,
  - (c) The remaining 10 Supervisory Contact Hours in either Individual or Group Supervision.

\*Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 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 phone number: \_\_\_\_\_

Name/Address of Clinical Facility/ Academic Site: \_\_\_\_\_

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: ____

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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.

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Signature of Approved Supervisor

Date

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

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.

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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.

- (a) 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:
  - 1. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
  - 2. 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:

_____ <b>LICENSE/CERTIFICATE #</b> _____
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**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:

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