Appendix A: Practicum Forms

Boston Graduate School of Psychoanalysis
1581 Beacon Street
Brookline MA 02446
617-277-3915

Statement Of Fieldwork Placement/Practicum Placement

To be filed with the Fieldwork Coordinator at the beginning of the placement

Please Print

Name of Student_____

Name of Placement Site_____

Address of Placement Site_____

Placement Site Contact_____

BGSP Clinical Group Supervisor (CP111)_____

BGSP Clinical Individual Supervisor (CP 341) _____

Date Placement Began_____

Summary of Duties_____

_____

_____

_____

_____

_____

_____

_____ Date_____
Student Signature

_____ Date_____
BGSP CP 111 Supervisor Signature

_____ Date_____
BGSP CP 341 Supervisor Signature

_____ Date_____
Fieldwork Coordinator Signature

Boston Graduate School of Psychoanalysis
Individual Supervision
• 1581 Beacon Street • Brookline , MA 02446 •
• Phone: 617-277-3915 • Fax: 617-277-0312 •

Statement of Individual Supervision

CP 341

All students in the counseling program are required to participate in minimally 12-13 hours of individual supervision during their practicum semester with a licensed mental health professional at the school. Students are encouraged to ask their 111 supervisors whether they are qualified to provide individual supervision as a licensed mental health professional. If so an arrangement may be made for individual supervision with the 111 supervisor. Individual supervision may be with up to 2 students.

I, _____

am in individual supervision with _____

for the semester of _____

Signatures:

_____ Date_____
Student Signature

_____ Date_____
Supervisor Signature

This section to be completed at the end of semester:

Semester: _____ Hours of Supervision Completed: _____

_____ Date_____
Supervisor Signature

Boston Graduate School of Psychoanalysis
1581 Beacon Street
Brookline MA 02446
617-277-3915

Fieldwork/Practicum Evaluation Form

(to be given to site contact after 1st semester of fieldwork)

Student: _____

Supervisor: _____

# of Client Hours on Site Per Week: _____

# of Additional Hours on Site Per Week: _____

Please write a brief evaluation of the student's work at your institution or agency.

Name and Address of Placement

_____

_____

_____

Placement Start Date: _____ Placement End Date: _____

_____ Date_____

Site Contact Signature

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. DO NOT ALTER THE FORM IN ANY MANNER. Forms with white-out, cross-out or copies will not be accepted.***

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 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/ 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):

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

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.

_____

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:

_____ ***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_____

Appendix B: Internship Forms

Boston Graduate School of Psychoanalysis
1581 Beacon Street
Brookline MA 02446
617-277-3915

Statement Of Counseling Internship Placement

To be filed with the Fieldwork Coordinator at the beginning of the placement

Please Print

Name of Student_____

Name of Placement_____

Address of Placement_____

Administrative Supervisor_____

BGSP Clinical Group Supervisor (CP111)_____

BGSP Clinical Individual Supervisor (CP 351) _____

Date Placement Began_____

Summary of Duties_____

_____

_____

_____

_____

_____

_____Date_____
Student Signature

_____Date_____
BGSP CP 111 Supervisor Signature

_____Date_____
CP 351 Supervisor Signature

Contract Signed and Submitted: Date_____

_____ Date _____
Fieldwork Coordinator Signature

Boston Graduate School of Psychoanalysis
• 1581 Beacon Street • Brookline, MA 02446 •
• Phone: (617) 277-3915 • Fax: (617) 277-0312 •

Statement of Individual Supervision (CP 351):

All students in the counseling program are required to participate in minimally 12-13 hours of individual supervision during their internship semester with a licensed mental health professional at the school. Students are encouraged to ask their 111 supervisors whether they are qualified to provide individual supervision as a licensed mental health professional. If so an arrangement may be made for individual supervision with the 111 supervisor. Individual supervision may be with up to 2 students.

I, _____

am in individual supervision with _____.

Semester: _____

Signatures:

_____

Student Signature Date

_____

Supervisor Signature Date

This section to be completed at the end of semester:

Semester: _____

Hours of Supervision Completed: _____

Supervisor Signature: _____ Date: _____

Boston Graduate School of Psychoanalysis
1581 Beacon Street
Brookline MA 02446
617-277-3915

Internship Supervision Evaluation Form

(to be given to site supervisor after 1st semester of Internship)

Student:_____

Supervisor:_____

# of Client Hours on Site Per Week: _____

# of Additional Hours on Site Per Week: _____

Please write a brief evaluation of the student's work at your institution or agency.

Name and Address of Placement:

_____

_____

_____

Placement Start Date: _____ Placement End Date: _____

Signature:_____

Date:_____

Boston Graduate School of Psychoanalysis
1581 Beacon Street
Brookline MA 02446
617-277-3915

Internship Supervision Final Evaluation Form

(to be given to site supervisor upon completion of Internship)

Student:_____

Supervisor:_____

# of Client Hours on Site Per Week: _____

# of Additional Hours on Site Per Week: _____

Please write a brief evaluation of the student's work at your institution or agency.

Name and Address of Placement:

_____

_____

_____

Placement Start Date: _____ Placement End Date: _____

Signature:_____

Date:_____

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):

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

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.

_____

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: _____