2024

Supervisee Onboarding Packet

MONTINA GALLOWAY

Welcome!

This is an exciting chapter of your career! Making the decision to impact others through improved mental health is admirable and much needed in the community. I was once where you are. When I made the decision to become a supervisor, I vowed to do all that I could to make sure newly licensed professionals are equipped with the tools they need to best serve clients.

Inside you will find:

- Supervision Agreement + Policies
- Supervision Professional Disclosure Statement
- Examples of Direct vs. Indirect Hours
- Examples of Important Board Required Forms

Please take a moment to read this packet carefully. It will give you a glimpse of what it is like to work with me in supervision.

Supervision Agreement + Policies

Below are other important points to consider before deciding to receive supervision from me:

- Communication Expectations
  - We have a professional relationship. This means that our interpersonal connection revolves around your professional growth and improved clinical outcomes for your clients. This requires adequate communication. You may call or text me during business hours 9 a.m. - 5 p.m. Monday - Friday. If you work a non traditional schedule, we can discuss how to go about this.
- Releases of Information
  - I require releases of information to be signed by you giving me permission to speak with your worksite supervisor. This ensures proper communication with all parties involved in order to provide your clients with the best possible care.
  - It is incredibly beneficial to you personally and professionally if you participate in your own individual therapy. When you do, I require releases of information to be signed by you giving me permission to speak with your personal mental health provider in the event there is a mental health issue that is impacting your work with clients. This ensures proper communication with all parties involved in order to provide your clients with the best possible care.
- Securing a Secondary Supervisor
  - It is strongly recommended that you secure a secondary supervisor in the event that I am unavailable or on vacation. If you need help finding one, we can work together on that.
- Technology
  - Due to the nature of our world (having most things virtually), I am willing to do a portion of our meetings virtually but majority of the time they will be in person, especially in the beginning. If you are not local to Charlotte, please let me know ahead of time.
  - Do not share your video/audio files with me electronically. During case presentations, you will either share your screen or bring in your recording device in person to complete the presentation.
  - In the event that technology fails during one of our supervision meetings, depending on the amount of time left in the meeting we will have to reschedule our time.
- Termination of Supervision
  - My hope for you is that you know where you stand at all times. So that by the time we submit quarterly and final reports to the North Carolina Board of Licensed Clinical Mental Health Counselors, you are not blindsided. If for any reason I have any concerns about your aptitude to be a competent licensed mental health counselor, I will let you know and work with you to create a performance improvement plan. If those attempts are unsuccessful, I will inform the board in writing about terminating our supervisory relationship.

Both parties agree to these terms and will abide by these guidelines.

Supervisee: ____________________ Date: ___________ Supervisor: _________________________ Date: ___________

Supervision Professional Disclosure Statement

Hello, it is my pleasure to welcome you to the mental health field. I am excited to work with you along your professional journey! The Supervision Professional Disclosure Statement is designed to inform you about me, and to ensure that you have a thorough knowledge of the supervisory relationship. Please read through this entire document in an effort to achieve a mutual understanding and to cover expectations about the supervision services that will be provided. The more informed you are the better decisions you can make for yourself and your career.

Qualifications

I earned a master's degree in Counseling & Development with a concentration in Clinical Mental Health from Winthrop University in 2016. I also earned a bachelor's degree in Family & Consumer Sciences from South Carolina State University in 2010. I have experience providing therapy to adolescents, adults, couples, and families since 2015. If I do not believe that I have the experience or training necessary to provide you with the best supervision experience, I will refer you to another qualified clinical supervisor that can support your training needs more effectively.

Licensure & Other Credentials

I am a Licensed Clinical Mental Health Counselor (12605) and a Qualified Clinical Supervisor (QS144762) practicing independently in the state of North Carolina, a registered telehealth provider in South Carolina (878) and a National Certified Counselor (756711). In November 2023, I completed the educational requirements to become a Qualified Clinical Supervisor. The exclusive Mirror in the Mirror supervision training program provided me the opportunity to receive education in multicultural/diversity awareness and sensitivity, build critical skills on how to provide effective feedback, selecting an appropriate supervision model, and helping you develop professional goals.

Theoretical Approach & Services Offered

In my therapy practice, I help Black women heal from the negative mental health impact of parentification. I provide psychotherapy for anxiety, depression, adjustment disorders, mood disorders, personality disorders, self-esteem, and grief. Although I hold Christian beliefs, I do not impose these beliefs onto the clients or supervisees that I serve.

It is my goal to cultivate a safe and comfortable environment which will allow each individual to grow in self-awareness and self-acceptance. My general approach is Person Centered, Cognitive Behavioral, and Solution-Focused Therapy; however, I may draw from many other techniques and theoretical approaches. Since my approach is eclectic in nature, I am able to add value in various ways to your supervision experience.

Supervision Professional Disclosure Statement

Nature of Supervision

Your supervision process begins with you first assessing what you need from a supervisor. What's important to you? What is your working style? Next, I will collect foundational information about you. Then, we examine your current work environment and set goals both clinical and non-clinical. Supervision includes your active involvement and effort to develop professionally by taking and giving feedback to your clients as well as me as your supervisor. You will be challenged to think critically about client cases and address your own personal issues that impede upon your therapeutic work with your caseload.

My model and approach to supervision is the Integrated Developmental Model (Stoltenburg, Delworth, and McNeil). This means that your training will be based on your developmental level, taking you from limited experience to a well integrated experienced clinician. I believe that your motivations, autonomy, and awareness of self and others should be strongly considered.

The goal of supervision is to improve your clinical effectiveness and outcomes for your clients. You will be responsible for submitting a completed case conceptualization form, either audio or video clips of client sessions to be reviewed and discussed each week, or be observed providing therapy sessions live. The evaluation procedures used in the supervisory relationship will cover both clinical and administrative aspects of your job. Your ability to communicate, attend supervision meetings on time, complete case presentations on time, and effectively support your clients will be evaluated.

Supervision Arrangements

Once your client caseload is at a consistent level, it is best to complete supervision on a weekly basis. We will coordinate and agree on a weekly meeting time that is feasible for both of us. Keep in mind, the North Carolina board has specific requirements for how many supervision hours are needed.

Supervisee's Responsibilities in Supervision

There are various expectations and activities along your supervision journey with me. They include but are not limited to you pre-selecting audio/video clips of sessions to present and then critique, completing homework or other assignments, keeping me informed regarding all client issues and progress, maintain liability insurance at all times (minimum $1M single incident/ $3M aggregate), and complete supervision record at each supervision session.

Supervisor's Responsibilities in Supervision

I also have a responsibility to you. I want this to be an enriching and rewarding learning experience for you. I commit to preparing for and attend all of our sessions, provide feedback each session, provide a formal evaluation at each quarter and at the end of the supervision contract, review your case conceptualization forms and other materials for quality control purposes, complete supervision record at each supervision session, and maintain licensure as a clinical supervisor in North Carolina.

Session Fees and Length of Service

Supervision sessions are scheduled to be approximately 50 minutes in duration depending on the type of service.

- Individual or Triadic Supervision: $110 (No more than 2 people) 50 minutes
- Group Supervision: $80 (3 or more people people) 2 hours

Supervision Professional Disclosure Statement

All major debit/credit cards are acceptable methods of payment. Payment for each supervision session is due prior to booking each session. Fees are reviewed periodically and will be increased to compensate for administrative costs and inflation. By consenting to this agreement, you acknowledge that these rates are in no way creating economic hardship for you personally.

In order to stay focused and progress towards the goals agreed upon, it is important to establish regularity among the supervision process. Certainly, situations will arise that prohibit sessions from occurring. However, it is my goal that the sessions begin and end on time. Please do not attend a session under the influence of drugs, alcohol, or any other mind-altering substance. If this occurs, you will be charged the full price of the session and the session will be canceled. Your services will be terminated without a refund of current or previous services and our supervisory relationship will be at risk of termination.

The focus of supervision is developmental in nature. Although I do not participate in legal, workplace, or disability matters, I have a requirement for supervisees to complete a release of information form giving me permission to speak with your worksite supervisor, your personal mental health provider, and/or any other involved parties. If you are not currently in therapy, I will refer or suggest one to you.

Explanation of Dual Relationships

It is important for you to realize that we have a professional relationship rather than a social one and I need to stay within the rules regarding dual relationships set forth by our professional ethics board. While I am working with you for supervision, you will be best served if our relationship stays professional and that our sessions concentrate exclusively on your goals and concerns for your career. Due to the nature of our relationship, I am unable to attend social gatherings, accept gifts, or relate to you in any way other than in the professional context of our supervision sessions.

Confidentiality

The issues you discuss in supervision will be confidential with the following exceptions:

1. Your performance and conduct in this clinical experience will be described in general terms when I submit quarterly reports and verification of supervision forms to the NC Board of Licensed Clinical Mental Health Counselors and other credentialing boards or when consultation with another professional is necessary.
2. If I am asked to provide information about your clinical experience in the form of a recommendation for a job, licensure, or certification.
3. Disclosures made in triadic or group supervision cannot be absolutely guaranteed as confidential. Although I will take every measure to encourage confidentiality and act appropriately if confidentiality is not upheld.

Emergencies, Cancellations, or Supervisor Vacations

If you are unable to attend your supervision session, I ask that you kindly give 24-hour's notice otherwise you will be charged for the ENTIRE AMOUNT of the scheduled supervision session ($80 or $110). Since sessions are prepaid, no refunds will be given if your session is canceled with less than 24 hours notice.

If you are having a personal mental health emergency and you are unable to reach me, you may reach out to The Smith Family Behavioral Health Urgent Care center first or Call 911. If you are having a client emergency, please feel free to call me at 704-750-1889. It is strongly recommended that you secure a secondary supervisor in the event that I am unavailable or on vacation.

Supervision Professional Disclosure Statement

Inclement weather or other emergencies may require rescheduling of appointments. Please provide a 24-hour notice for the cancellation OR rescheduling of an appointment. If you have canceled or rescheduled more than 3 designated appointment times within a given month without notification 24-hours prior, your supervision services will be terminated. No refunds will be given for current or previous services provided.

In the event that I need to cancel a session, I will contact you as quickly as possible. I will make every attempt possible to contact you at home, work, or on your cell phone to arrange another appointment. I will inform you of scheduled vacations at least 1 week in advance. During this time or when I am otherwise unavailable, you may leave a message for me.

Complaints
If you are dissatisfied with my services or feel that you have been treated unfairly or unethically, I ask that you address this with me immediately. I have an open door communication policy. This will make our work together more efficient and effective for you. If you have addressed this issue with me but feel you have failed to get this resolved, you may contact the organization below for clarification of your rights or log a complaint. However, you have my personal guarantee that I will do everything I can to resolve your concern. As a professional, I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: (844) 622-3572 or (336) 217-6007
Fax: (336) 217-9450
E-mail: complaints@ncblcmhc.org

Acceptance of Terms
Both parties agree to these terms and will abide by these guidelines.

Supervisee: ________________________ Date: __________

Supervisor: ________________________ Date: __________

Direct vs Indirect Hours

Direct Hours Live contact with individuals, groups, or families through counseling/psychotherapy	Indirect Hours Counseling-related work such as phone calls and paperwork
Case Consultation Working with the on-site supervisor to gain ideas, discuss any dilemmas and/or progress, and facilitate a treatment plan (this is NOT supervision)	Supervision Regular weekly on-site interaction with an average of one (1) hour per week of individual and/or triadic supervision (no more than two students per supervisor constitutes triadic)
Direct Participation in client-related activities Participating in client activities such as play therapy, art therapy, and associated activities, i.e., engaging in an activity with a family/couple's children while the family/couple receives counseling from another clinician.	Team supervision sessions Company clinicians/Interns class attendance
Intakes/Interviews with clients Completing intakes in person and/or over the telephone	Research and preparation for a session with a client Clinician/Intern may want to learn more about a particular disorder and review treatment manuals and other technique resources in order to be better prepared to work with a client(s).
Individual Counseling Counseling individual clients and/or co-leading sessions with the site supervisor.	Case Notes The clinician/intern is to keep updated case notes on clients assigned; which includes progress notes, diagnoses, and obstacles.
Group Counseling Counseling multiple clients with a specific goal and/or support as the focus (i.e., clients dealing with cancer).	Case Management The clinician/intern will help in the assessing of service needs, care planning, implementation of treatment plans and scheduling of clients with the site supervisor.
Family/Couples Counseling Counseling families/couples and/or co-leading sessions with the site supervisor.	Creating activities for clients Creating activities that are original and relevant to the client and finding activities from credible and relevant sources (i.e., Empirical tested workbooks, treatment manuals).
Testing/Assessment Conducting suicide risk assessments and/or various other personality and/or risk assessments, i.e., depression inventories, etc. with a client.	Other activities In-services, training offered by the site, staff meetings (not parties); setting up appointments, filing paperwork/forms, making telephone calls/answering telephone, and other clerical duties to provide supportive resources for the site. Assisting other clients with the completion of paperwork or forms for the site (not the intern's assigned clients).

NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
FAX: 336-217-9450
WEB: ncblcmhc.org
EMAIL: LCMHCinfo@ncblcmhc.org

Supervision Contract

Indicate to which LCMHC Associate this contract applies:

LCMHC Associate Name: ____________________ LCMHCA (#__________)

INSTRUCTIONS: FORMS CAN BE MAILED, FAXED OR EMAILED

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this supervision contract.
2. **ALL SECTIONS** must be completed or the supervision contract will be returned.
3. The supervision contract should be mailed to the **NCBLCMHC Board Office at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417, or Faxed to: 1 (336)217-9450, or emailed: Supervision@ncblcmhc.org**

Date Received: __________
Approved by: __________
Date Approved: __________

4. This supervision **contract must be received and approved by the NCBLCMHC prior to initiation of supervision.**

I. GENERAL INFORMATION - (*Supervisor Information*)

Supervisor's Name (Last, First, Middle): ____________________

(*LCMHC, LCSW, etc.*) __________
License Type/Number: __________
Issuance Date: __________

Mailing Address (Name of Workplace, Mailing Address, City, State, Zip Code):

____

____

Business Phone: __________

Mobile Phone: __________

Email Address: ____________________

II. SUPERVISION - *To be completed by supervisor. Clinical Supervision is defined in Rules .0208 through .0212.*

Is this an exempt setting (school, university, government agency)? ☐ **Yes** ☐ **No**

Location of Supervision— provide name of workplace, physical address and a contact phone number:

Physical Address (Street, City, State, Zip Code): ____________________

____

Business Phone: __________

Modality of Supervision to be Used - each supervision session shall utilize **at least one** of the following (check all that apply):

☐ Live Observation/Supervision ☐ Co-therapy ☐ Audio Recording ☐ Video Recording

Frequency of Supervision (minimum one hour of individual or two hours of group supervision per 40 hours of counseling practice as defined in Rule .0208. At least three-quarters of the hours of clinical supervision shall be individual.):

The supervisee will receive a minimum of _____ hours of individual clinical supervision ☐ weekly ☐ biweekly ☐ monthly or a minimum of _____ hours of group clinical supervision ☐ weekly ☐ biweekly ☐ monthly

Explanationofhours(ifnecessary): ____________________

III. SUPERVISOR CREDENTIALING - *If proposed supervisor is a NC Licensed Clinical Mental Health Counselor Supervisor (LCMHCS), skip to signatures.*

*The following documentation **must** be submitted with this Supervision Contract:*

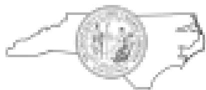
Official transcript documenting the equivalent of 3 semester graduate credits in clinical supervision from a regionally accredited institution of higher education or 45 contact hours of continuing education in clinical supervision as defined by Rule .0603(c).

I agree to assume responsibility for the clinical work and preparation of this supervisee and will be available for consultation with the Board or its committees regarding the supervisee's competence.

Supervisor's Signature: ____________________ Date: __________

I understand and will abide by the requirements and expectations of supervision and the standards of clinical practice as defined by the Board.

Supervisee's Signature: ____________________ Date: __________



NORTH CAROLINA BOARD of LICENSED CLINICAL MENTAL HEALTH COUNSELORS

P.O. Box 77819 | Greensboro, North Carolina 27417

Quarterly Supervision Report

To be filed for LCMHCAs with approved supervision contracts.

Indicate to which LCMHC Associate this quarterly supervision report applies:

LCMHC Associate Name:______________________________ LCMHCA (#____________)

FORMS CAN BE MAILED, FAXED OR EMAILED
PRINT or TYPE using BLACK Ink to complete this supervision contract.
ALL SECTIONS must be completed or the supervision contract will be returned.
The supervision contract should be mailed to the NCBLCMHC Board Office at: NCBLCMHC, PO Box77819, Greensboro, NC 27417, or Faxed to: 1 (336)217-9450, or emailed: Supervision@ncblcmhc.org

I. GENERAL INFORMATION - *(Supervisor Information.)*

Supervisor's Name (Last, First, Middle):

Mailing Address (Name of Workplace, Street and/or Box Number, City, State, Zip Code):

Business Phone:

Email Address:

Mobile Phone:

II. SUPERVISION - *To be completed by supervisor.*

Supervision Period: Year: ________ **For a Partial Quarter:** Begin Date (m/d/yr) ____________ End Date (m/d/yr)____________

Full Quarters: ☐ Quarter 1 (1/1—3/31) ☐ Quarter 2 (4/1 - 6/30) ☐ Quarter 3 (7/1 - 9/30) ☐ Quarter 4 (10/1 - 12/31)

Supervised Professional Practice and Clinical Supervision:

I attest to the following:

Yes	No	
☐	☐	The supervisee received a minimum of 1 hour of individual or 2 hours of group clinical supervision per 40 hours of supervised professional counseling practice.
☐	☐	The focus of the supervision session was on raw data from clinical work that was made available to me through such means as: live observation, co-therapy, audio and video recordings, and/or live supervision.

(Reminder: At least three quarters of the hours of clinical supervision shall be individual.)

Yes	No	
☐	☐	If individual clinical supervision was received, it was face-to-face supervision with 1 or 2 supervisees and me, for a period no less than 1 hour of clinical supervision per session. ☐ Check here if no individual supervision was received.
☐	☐	If group clinical supervision was received, it was face-to-face supervision, between groups of supervisees (no more than 12 supervisees per group) and me, for a period no less than 2 hours of clinical supervision per session. ☐ Check here if no group supervision was received.
☐	☐	The supervisee and I are maintaining a clinical supervision log of hours that includes the date; start and stop times; the modality of supervision provided; and notes on recommendations or interventions used during the supervision.
☐	☐	There are ethical and/or legal concerns regarding the supervisee that I believe the Board should be made aware of. If yes, please explain and cite the NC Statutes or ACA ethical codes that you feel have been violated. Please attach additional sheets if necessary.

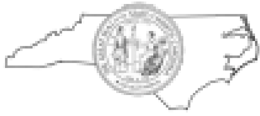
____
____
____

I verify that the above information is accurate. I am available for consultation with the Board or its committees regarding the supervisee's competence.

For electronic report submissions (ONLY): I understand that typing my first and last name on the signature line below will be considered to be my electronic signature that has the same legal effect and can be enforced in the same way as my written signature.

Supervisor's Signature: ______________________________ Date: ______________

A Final Supervision Report form must be submitted to the Board within two (2) weeks of termination of supervision and within two (2) weeks of a change in the conditions specified in the supervision contract from on file with the Board.



NORTH CAROLINA BOARD of LICENSED CLINICAL MENTAL HEALTH COUNSELORS

Final Supervision Report

Indicate to which LCMHC Associate this final supervision report applies:

LCMHC Associate Name: ______________________ LCMHCA (#_____)

INSTRUCTIONS: FORMS MUST BE MAILED, FAXED OR EMAILED

1. **PRINT** or **TYPE** using **BLACK** ink to complete this final supervision report.
2. **ALL SECTIONS** must be completed or the final supervision report will be returned.
3. The Final Supervision Report should be mailed in a sealed envelope, **signed across the sealed flap**, to the **Board Office at: NCBLCMHC, PO Box 77819, Greensboro, NC 27417, Supervision@NCBLCMHC.ORG**

I. GENERAL INFORMATION - *Supervisor's Information*. Supervisor's Name (Last, First, Middle):

Mailing Address (Street and/or Box Number, City, State, Zip Code):

Business Phone:

Email Address:

Mobile Phone:

II. FINAL SUPERVISION - *To be completed by supervisor. Dates must be entered to be considered complete.*

Supervision Period: Begin Date (mm/dd/yy)__________ End Date (mm/dd/yy) __________

Modality of Supervision Used (check all that apply):

☐ Live Observation/Supervision ☐ Co-therapy ☐ Audio Recording ☐ Video Recording

Supervised Professional Practice and Clinical Supervision: (Please enter total hours of supervision)

Supervised Professional Practice (as defined in Rule .0208): **Total # Hours Indirect** Counseling: __________

(no more than 40 per week) **Total # Hours Direct** Counseling: __________

Individual Clinical Supervision (as defined in Rule .0210): Total # Hours: ________ *(no less than 1hr per 40 hrs worked)*

Group Clinical Supervision (as defined in Rule .0211): Total # Hours: ________ *(no less than 2hrs per 40 hrs worked)*

III. SUPERVISION SUMMARY - *To be completed by supervisor. Please provide a summary of the supervision activities completed with this supervisee as well as identify strengths and potential deficits of the supervisee. Attach additional pages as needed.*

Name of Applicant: *(Required)*______________________________

IV. PROFESSIONAL ASSESSMENT - *To be completed by supervisor.*

Please rate the applicant compared to other counselors you know on the characteristics listed below. Place a mark in the appropriate column for each characteristic using the following rating scale:

1 = Outstanding 2 = Above Average 3 = Average 4 = Below Average 5 = Not Qualified 6 = Cannot Evaluate

	1	2	3	4	5	6	Comments
Individual counseling skills							
Diagnostic skills							
Treatment planning implementation							
Appropriate referral making							
Appropriate record keeping							
Group counseling skills							
Personal integrity							
Consulting skills							
Insight into client's problems							
Ability to relate to co-workers							
Ability to be objective on the job							
Knowledge of assessment instruments							
Ethical conduct							
Concern for the welfare of clients							
Sense of responsibility							
Recognition of own limits							
Ability to keep material confidential							

V. REFERENCE - *To be completed by supervisor.*

I ☐ recommend ☐ do not recommend this applicant for unrestricted licensure as a NC Licensed Clinical Mental Health Counselor.

INITIAL (Required)____________________

If you do not recommend this application for unrestricted licensure please indicate below your reasons why:

____

____

____

VI. VERIFICATION - *To be completed by supervisor.*

I verify that the above information is accurate. The focus of the documented supervision sessions was based on raw data from clinical work which was made available to the supervisor through such means as live observation, co-therapy, audio and video recordings, and live supervision. The clinical supervision included a minimum of one hour of individual or 2 hours of group clinical supervision per 40 hours of counseling practice.

Supervisor's Signature: ______________________________ **Date:** ______________

After completing this form, please enclose it in a **sealed envelope**, **sign across the sealed flap**, and **return** to the NC Board of Licensed Clinical Mental Health Counselors.

2024 Supervisee Onboarding Packet