Board of Professional Counselors and Therapists
4201 Patterson Avenue
Baltimore, MD 21215
410-764-4732
www.dhmh.maryland.gov/bopc

Required Supervised Clinical Experience – LCPC

** "**Clinical professional counseling means** the engagement in professional counseling and appraisal activities by providing services involving the application of counseling principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems, emotional conditions or mental conditions of individuals or groups". (Health Occupations Article Title 17)*

Years of Experience: 3	**Total Clinical Hours: 3000**	**Direct Clinical Client Contact Hours: 1500**	**Indirect Clinical Hours: 1500**	**Face to Face Clinical Supervision Hours: 100**
Three years of supervised clinical experience is required. Two of the three years of experience must be earned post master's degree.	A total of 3000 hours of supervised clinical experience is required, of which 2000 hours must be acquired post master's degree. Up to 1000 master's level practicum hours may be included in the total 3000 hours.	A minimum of 1500 face to face clinical client contact hours are required. These are direct session times providing clinical professional counseling* to clients who are physically present.	A maximum of 1500 hours of indirect clinical services may be included in the required total of 3000 clinical hours. Indirect clinical hours include all case management and professional development activities (including face to face clinical supervision) related to the provision of clinical counseling services in an agency or private supervised setting.	100 hours of face to face clinical supervision by an approved supervisor is required post master's degree. A minimum of 50 hours must be individual supervision. A maximum of 50 hours may be group supervision. An "approved supervisor," must be an LCPC or another fully licensed mental health care provider, although a minimum of 50 of the 100 hours of clinical supervision must be provided by an LCPC approved supervisor.

Glossary of Terms

1. **"Face-to-face client contact hour"** means direct session time with clients physically present.

2. **"Face-to-face clinical supervision**" means direct supervision time with the supervisee and supervisor physically present. These must be post Master's degree hours. As part of the 3,000 clinical supervised hours, 100 of the indirect clinical hours are face to face clinical supervision hours with a licensed supervisor approved by the Board.

3. **"Approved supervisor,"** means a licensed clinical professional counselor or another heath care provider under the Health Occupations Article, Annotated Code of Maryland. Examples: Psychologist, Psychiatrist, Clinical Social Worker, Psychiatrist Nurse

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Direct Clinical Client Contact Hours: 1500 (minimum)

Session time with client and/or significant others providing face-to-face clinical counseling that includes, but is not limited to the following:

Individual counseling
Group counseling
Family counseling
Couples counseling
Evaluation
Intake/Assessment
Diagnosis
Treatment planning with client
Crisis management/intervention

Indirect Clinical Hours: 1500 (maximum)

These hours consist of all case management and professional development activities related to the provision of clinical professional counseling services in an agency or private practice setting. The following are specific examples of clinical activities that fulfill the indirect clinical hour requirement.

Referral
Intake/assessment by telephone or other means when client is not face to face
Receiving individual and group supervision at site or at the university
Consultation with other professionals
Treatment planning with other professionals
Case staffing
Staff meetings
Related trainings and seminars
Record keeping
Report writing
Case Notes
Providing clinical training
Telephone triage
Case management
Program development
Other clinical professional counselor administrative duties as required by the setting in which the clinical hours are accrued.

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SUPERVISED CLINICAL DOCUMENTATION FORM

The Information provided on this form must be completed by the applicant's supervisor(s) at the agency or organization(s) where the applicant was employed for the period of time claimed. **This form should be photocopied and completed for each separate counseling experience claimed to meet the required clinical supervision including your practicum or internship, if applicable.** Please review the table and glossary of terms to help you understand the requirements.

APPLICATION DATE:

Please Type or Print all Information:

APPLICANT'S NAME AND CONTACT INFORMATION

1. Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
		Last	First	MI
2. Social Security Number:				
3.Name and address of organization, agency or any other counseling setting where the applicant gained supervised experience:	Name:			
Address:				
	Street	City	County	State / Zip Code

4. Did this applicant perform 3,000 clinical hours under your supervision?

☐ Yes ☐ No. If no, how many hours

5. From:	To:
(Month/Day/Year)	(Month/Day/Year)

6. Did this applicant complete 1,500 face-to-face client contact hours under your supervision with client(s) physically present? ☐ **Yes** ☐ **No**

If no, indicate the number of hours:

7. Did you provide 100 post master's degree face-to-face clinical supervision hours with this applicant?

☐ **Yes** ☐ **No.** If no, indicate the number of hours:

100 post master's clinical supervision hours with the supervisor physically present is required. These hours must be completed after the transcript date the Masters Degree was conferred.

8 Are you a licensed Professional Counselor?

☐ **Yes** ☐ **No**

License Number: State: Expiration Date:

9. Are you licensed as another mental health care provider? ☐ **Yes** ☐ **No**

If yes, ***where*** are you licensed? State: License Number: Expiration Date:

10. As supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of counseling? ☐ Yes ☐ No

If yes, please specify (attach additional sheet if necessary)

I VERIFY THE INFORMATION ON THIS FORM IS ACCURATE FOR THE APPLICANT			
(Supervisor Print Name)			(Supervisor's Signature)
Address:			
(City)	(State)	(Zip)	(Phone)
	Witnessed by		
Name of Notary			