

Board of Licensed Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

LPC/MHSP Policy on Supervision for Licensure

This policy is intended to provide guidance to applicants for licensure as Licensed Professional Counselors with a Mental Health Service Provider designation.

1. **Temporary license:** Although the temporary license is not required for applicants pursuing their post-graduate hours, the temporary license is highly recommended for the following reasons, including but not limited to:
 - It lets the board know the applicant is working towards licensure.
 - It enhances the probability of securing an approved supervisor if the applicant has the temporary license or is working toward securing it.
 - It requires the applicant to identify their primary supervisor as an approved supervisor at the onset.
 - For applicants working in agencies, it may result in additional pay.
 - The temporary license allows the applicant to receive direct payment while working under supervision in a clinical setting.

2. **Supervisor-Supervisee Agreement:** Prior to the beginning of post-graduate supervision, supervisees are encouraged to obtain a Supervisor-Supervisee Agreement with any individual providing supervision toward licensure requirements.
 - The Supervisor-Supervisee Agreement should verify that **all clinical supervisors** meet the qualifications of an approved supervisor.
 - In workplace settings, Applicants should establish at the outset if the supervisor-supervisee relationship is for the purpose of clinical supervision for licensure, or for administrative purposes only.

3. **Request for Temporary License form:** When applying for a temporary license, the **Request for Temporary License** form requires a signature from the supervisee's **primary supervisor**.

4. **Primary supervisors/additional supervisors:** Supervisees must have one (1) approved **primary supervisor** and may have **additional approved supervisors**.
 - At the time of application for independent licensure, Supervisees must submit information to the board administrative office about all supervisors.
 - This information must include proof that all supervisors met the approved supervisor requirements when supervision occurred.

5. **Reporting requirements:**
 - The **primary supervisor** reports supervision hours, the time period over which these supervision hours were completed, and the **direct and indirect clinical hours of the supervisee**.
 - If the supervisee has **additional supervisors**, the supervisee must report this fact to the **primary supervisor**.
 - In cases where the **additional supervisor** is supervising direct and indirect hours of the supervisee not known by the **primary supervisor**, it is the responsibility of the **supervisee** to report these direct and indirect hours to the **primary supervisor** with supporting documentation from **additional supervisors**.
 - **Primary supervisors** assume responsibility to coordinate with any **additional supervisors**. The

primary supervisor is not responsible for the content or quality of the supervision provided to the supervisee by any **additional supervisors**.

6. **Additional supervisor requirements:** The responsibility of **additional supervisors** is to report the number of supervision hours, whether group or individual, that they have provided to the supervisee. **Additional supervisors never report clinical (direct or indirect) hours of the supervisee on the Verification of Supervised Post-Graduate Experience form.**
7. **Supervisor changes:** Supervisees working under a temporary license who change their **primary supervisor** must submit this information to the Board by filling out the **Request for Temporary License** form found on the board's website and may email the completed form to Unit1HRB.health@TN.gov. If a supervisee finds it necessary to change **additional supervisor(s)**, the supervisee must notify their **primary supervisor** of this change in writing.
8. **Review of supervision logs:** It is recommended that supervisees and their **primary and/or additional supervisors** periodically review supervision logs and verify the total supervision and clinical (direct and indirect) hours completed to eliminate potential discrepancies. The Board reserves the right to deny hours that cannot be substantiated or verified.
9. **Supervision frequency:** Supervision should be provided over time at sufficient frequency to ensure adequate learning and guidance based upon actual client contact hours. Client contact hours are defined as a 50- minute period, pursuant to Rule 0450-01-.01.
10. **Supervision purpose:** The supervision must be for the direct provision of mental health services by the supervisee to individuals or groups of clients, pursuant to 0450-01-02.
11. **Supervision hour:** A supervision hour is a 50 to 60-minute period that a supervisee and supervisor spend in supervision together. Supervision meetings that are less than 50 minutes or more than 1 hour are to be rounded to the nearest quarter hour when recorded and reported to the Board.

Approved by the Board of Licensed Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists the 22nd day of September, 2025.

Kimberly D. Speakman
Kimberly D. Speakman | Sep 22, 2025 14:46:17 (DT)

President
Board of Licensed Professional Counselors, Marital and
Family Therapists, and Clinical Pastoral Therapists

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

(If you had more than one supervisor, please have each supervisor complete a separate form)

SUPERVISOR: PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS AT THE END OF THE FORM. TYPE OR PRINT LEGIBLY.

THE SUPERVISOR MUST COMPLY WITH THE FOLLOWING:

1. **Been licensed as an LPC, LPC-MHSP, LMFT, licensed psychologist, psychiatrist or LCSW for at least five (5) years; for MHSP status one may not be supervised by an LPC and one half of the hours MUST be supervised by an LPC/MHSP**
2. **Comply with Section F of the current code of ethics adopted by the American Counseling Association, except to the extent that it conflicts with the laws of the State of Tennessee or the Rules of the Board.**
3. **Complete twelve hours (12) training in supervision as defined by the Rule 0450-01-.10(1)(d) and submit verification of the hours with this form.**
4. **Provide supervision based on the definition of supervision as defined by Rule 0450-01-.10(2).**

Name Of Applicant: _____

Supervisor's Name: _____

Supervisor's Address _____

Supervisor's Email address: _____ Telephone Number: _____

Approved Supervisor Yes No _____ Date of approval _____

Supervisor's License Number _____ State _____ Type Of License _____

If License is M.D. Or D.O., are you certified by The American Board of Psychiatry and Neurology? Yes No

Date of initial license: _____ Expiration date of license: _____

Is your license in good standing? Have you ever had any disciplinary action taken against you or your license? Yes No

If Yes, Please Explain: _____

What was the job title of applicant during the time of your supervision: _____

Dates Of Supervision: From _____ To _____

What activities did/does your clinical supervision include:

- | | |
|--|--|
| <input type="checkbox"/> sign off on charts | <input type="checkbox"/> treatment planning (for MHSP) |
| <input type="checkbox"/> discuss individual cases briefly | <input type="checkbox"/> DSM/diagnosis (for MHSP) |
| <input type="checkbox"/> discuss individual cases in depth | <input type="checkbox"/> member of treatment team |
| <input type="checkbox"/> other (describe) _____ | |

Location Where Clinical Experience Took Place: _____

Description of Clinical Experience: _____

_____ Total Individual Supervision Hours	_____ Total Clinical Hours (Individual, Group, Family)
_____ Total Group Supervision Hours	_____ Total Other Hours (Paperwork, Training, Etc.)
_____ Total ALL Supervision Hours	_____ Total ALL Hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

Supervisor's Signature

License No.

Date

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____

NOTARY PUBLIC

MY COMMISSION EXPIRES _____

AFFIX SEAL HERE

Send to:

Board for LPC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

This Form May Be Duplicated

VERIFICATION OF SUPERVISED POST-GRADUATE EXPERIENCE
(If you had more than one supervisor, please have each supervisor complete a separate form)

SUPERVISOR: PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS AT THE END OF THE FORM. TYPE OR PRINT LEGIBLY.

THE SUPERVISOR MUST COMPLY WITH THE FOLLOWING:

1. **Been licensed as an LPC, LPC-MHSP, LMFT, licensed psychologist, psychiatrist or LCSW for at least five (5) years; for MHSP status one may not be supervised by an LPC and one half of the hours MUST be supervised by an LPC/MHSP.**
2. **Comply with Section F of the current code of ethics adopted by the American Counseling Association, except to the extent that it conflicts with the laws of the State of Tennessee or the Rules of the Board.**
3. **Provide documentation of required training per Rule 0450-01-.10(1)(e). If required training was completing twelve hours (12) clock hours in supervision submit verification of the hours with this form.**
4. **Provide supervision based on the definition of supervision as defined by Rule 0450-01-.10.**

TO BE COMPLETED BY THE SUPERVISEE

Supervisee's Name: _____

Temporary License Number (if applicable): _____ Date of Birth: _____

TO BE COMPLETED BY THE QUALIFIED SUPERVISOR WHETHER PRIMARY OR ADDITIONAL SUPERVISOR

Check the appropriate box: PRIMARY SUPERVISOR ADDITIONAL SUPERVISOR

Supervisor's Name: _____

Supervisor's Address _____

Supervisor's Email address: _____ Telephone Number: _____

Supervisor's License Number _____ State _____ Type Of License _____

Date of initial license: _____ Expiration date of license: _____

License in good standing? Yes No

Have you ever had any disciplinary action taken against you or your license? Yes No

If Yes, Please Explain: _____

Dates Of Supervision From _____ To _____

What activities did/does your clinical supervision include:

- | | |
|--|--|
| <input type="checkbox"/> sign off on charts | <input type="checkbox"/> treatment planning (for MHSP) |
| <input type="checkbox"/> discuss individual cases briefly | <input type="checkbox"/> DSM/diagnosis (for MHSP) |
| <input type="checkbox"/> discuss individual cases in depth | <input type="checkbox"/> member of treatment team |
| <input type="checkbox"/> other (describe) _____ | |

Location Where Clinical Experience Took Place: _____

SUPERVISION HOURS TO BE COMPLETED BY THE PRIMARY AND/OR ADDITIONAL SUPERVISORS

_____ Total Individual or Triadic Supervision Hours
_____ Total Group Supervision Hours
_____ Total ALL Supervision Hours

POST GRADUATE HOURS TO BE COMPLETED BY THE PRIMARY SUPERVISOR ONLY

It is the responsibility of the primary supervisor and only the primary supervisor to report the supervisee's total post graduate hours – both direct and indirect.

_____ Total Clinical Direct Hours (Individual, Group, Family)
_____ Total Indirect Hours (Paperwork, Training, etc.)
_____ Total ALL Hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

Supervisor's Signature

License No.

Date

SWORN TO BEFORE ME THIS _____ DAY OF _____,

NOTARY PUBLIC

MY COMMISSION EXPIRES _____

AFFIX SEAL HERE

Send to:

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Nashville, TN 37243

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