



Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Renee Mallory, RN, BSN, Interim Secretary of Health
Jennifer Dillaha, MD, Director

—Supervision Agreement and Plan—

There must be supervision agreements for all areas of practice and psychological services being provided by the supervisee during the period of supervision covered. Supervision can exclude areas of practice on the supervisee’s statement of intent that the supervisee is not currently engaging in.

Supervisee’s Name (PRINTED): _____ License Number: _____

Supervisor’s Name (PRINTED): _____ License Number: _____

Please indicate reason for filing this supervision agreement. A licensee or provisional licensee may have more than one supervisor on file. Any supervisor who is not the primary supervisor is a secondary supervisor.

- New Primary Supervisor New or Additional Secondary Supervisor

Psychological services to be provided **under supervision**. (Do not list services that will be provided independently.)

1. Areas of practice:

- Psychoeducational Testing Diagnostic Interviewing Individual Therapy
- Objective Personality Testing Family Therapy Group Therapy
- Projective Tests Hypnosis Couples/Marital Therapy
- Biofeedback Consultation
- Neuropsychology (psychologists and grandfathered LPEs only) Other (specify)

2. Populations to be served: Child Adolescent Adult Geriatric

3. Plan of Supervision. For provisional licensees **one hour per week** of individual, face to face supervision, or the equivalent, is generally required.

Type of Supervision	Frequency	Length of Sessions
Individual face to face	<input type="checkbox"/> Twice per week <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly	
Group	<input type="checkbox"/> Twice per week <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly	
Phone	<input type="checkbox"/> Twice per week <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly	
Other (specify)	<input type="checkbox"/> Twice per week <input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly	

Goals of Supervision: _____

Note: Both the Supervisee and Supervisor are responsible for ensuring supervision is conducted as agreed. If the supervisor becomes unavailable or incapacitated, the supervisee must inform the board within ten working days. Do not provide psychological services without supervision.

I agree to the plan of supervision above and agree to abide by the rules and requirements for supervision enumerated in § 6.2 and 6.3 of the Arkansas Psychology Board’s Rules and Regulations.

Supervisee’s Signature: _____ Date: _____

I have read the supervisee’s Statement of Intent and agree to supervise him or her as required per § 6.3.C of the Arkansas Psychology Board’s Rules and Regulations. Any areas of practice that the supervisee will engage in that are not within my own Statement of Intent to Practice are listed below with the arrangements that have been made for additional supervision.

Supervisor’s Signature: _____ Date: _____