



Counselor, Social Worker & Marriage and Family Therapist Board

50 West Broad St, Suite 1425

Columbus, Ohio 43215-5919

614-466-0912 & Fax 614-728-7790

<http://cswmft.ohio.gov> & cswmft.info@cswb.state.oh.us

Supervising Counselor Designation Application

1. Name:		SSN:	
2. Street Address:		City:	State: Zip:
3. Daytime Phone:	Email:		County:
4. License #:	License Issue Date:	Expiration Date:	
5. Licensed three years as a counselor: <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. For PC applicants only: have you completed four thousand five hundred hours experience post licensure including, but not limited to, work in areas such as career counseling, personal growth, supervised diagnosis and treatment of mental and emotional disorders, etc. All supervision of diagnosis and treatment of mental and emotional disorders shall be per section 4757.21 of the Revised Code and rules 4757-15-01 and 4757-15-02 of the Administrative Code. <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. For PCC applicants only: have you obtained a minimum of one year and fifteen hundred hours of clinical experience, post professional clinical counselor licensure, which shall include the diagnosis and treatment of mental and emotional disorders. <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. PCC document post PCC one year and fifteen hundred hours of clinical experience: (where did you work, hours & dx/tx). PC document post PC three years and forty five hundred hours of clinical experience: (where did you work, hours & dx/tx).			
Employer:		Address:	Hours:
9. Supervisor's Name:		License Number:	Exp. Date:
10. Can you document two quarter hours of academic work or 24 clock hours of continuing education hours in clinical supervision from programs or institutions approved by the counselor professional standards committee. (Please attach copies or certificates). <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. I will comply with all current or future Association for Counseling Education and Supervision (ACES) and American Counseling (ACA) ethical standards pertaining to the supervisory relationship: Signature: _____ Date: _____			
12. Have you ever had a license suspended, revoked or denied in Ohio or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please explain			
13. Have you ever been disciplined by any licensing agency in Ohio or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please explain.			

14. Document applicant's familiarity with significant legal, ethical, and clinical issues relevant to the supervisory relationship. List relevant courses and experience:

15. Have you been brought up on charges of a breach of ethics with the American Counseling Association (ACA) or the Association for Counseling Education & Supervision (ACES)? Yes No If yes, please explain.

16. Have you had any felony convictions since receiving your license? Yes No. If yes, please explain.

17. Have you completed at least one supervision of supervision experience, which has been supervised for a minimum of five hours and consists of the applicant providing ten hours of supervision to at least one supervisee. The supervisor providing supervision of the supervision process shall be a professional clinical counselor with a supervising counselor designation.

A. Name/ Lic. # of Supervisor: _____

B. Who did you supervise when/where: _____

C. Site of supervision: _____

C. Signature of Supervisor: _____

18. Memo of Understanding: I have read the counselor licensure law and understand the rules and regulations that pertain to Professional Clinical Counselors with Supervision Designation. I further understand that any person who knowingly makes a false statement on the application form is guilty of falsification under section 2921.13 of the Ohio Revised Code, a misdemeanor of the first degree.

“By virtue of filling this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, and that the information given in this application is true, correct, and complete to the best of my knowledge. I hereby authorize the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board to verify any and all information contained in this application, including information maintained in applicable data banks, and to transmit this information to the licensing authority of the state to which this application is made. I authorize the licensing authority of the state where application is submitted to review state files pertaining to my licensure and practice, and law enforcement and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority.”

Signature of applicant: _____

Signature of notary public: _____

Subscribed and sworn to before me this _____ day of 20_____.

My commission expires _____

SEAL