Certified Mental Health Professional – Tier 2
On-the-Job Supervision Verification Form

DIRECTIONS

This form allows for one qualified supervisor to document clinical on-the-job supervision hours as required for the CAP credential. Provide a separate form and instructions to each qualified supervisor who will document supervision for certification purposes. FCB has supervision documentation templates posted online that may be used if needed.

All information must be TYPED. Handwritten forms will be denied. This is a two-part form.

- Part One is completed by the applicant and provided to the qualified supervisor.
- Part Two is completed by the qualified supervisor and provided to FCB by mail, email or fax (see below).

Upon completion, please submit the form and supporting documentation directly to the FCB. *On-the-Job Supervision Verification Forms* will not be accepted from the applicant.

Mail: Florida Certification Board
Attn: Certification Operations
1715 South Gadsden Street
Tallahassee FL 32301

Email: Certification Specialist's email or admin_assist@flcertificationboard.org
Fax: 850-222-6247
Subject Line: On-the-Job Supervision (applicant name)

REQUIREMENT

Policy Standard	Supervision focuses on improved client care and improved job performance. The purpose of supervision is to teach counselors how to promote client welfare and increase their skills and knowledge in order to effectively treat their client base. Supervision for certification purposes can be individual, one-on-one supervision and/or observation of skills OR group supervision/case staffings. At least 50% of the hours of supervision must be individual, one-on-one supervision and/or observation skills. No more than 50% of the required hours of supervision may be in a group setting. See *Candidate Guide: Application Process* for additional details and guidance.
CMHP Description	An unlicensed practitioner who possesses competence in providing direct services in mental health inpatient and outpatient settings.
Qualified Supervisor Definition	A qualified supervisor must be current and fall within one of the following designations: • A physician or physician's assistant licensed under Chapters 458 or 459, F.S. • A professional licensed under Chapters 490 or 491, F.S. • A Psychiatric Advanced Registered Nurse Practitioner licensed under Part 1 of Chapter 464, F.S. and meeting the Board of Nursing requirements for a Psychiatric ARNP designation. • A MCAP or CAP • A CMHP with a Master's Degree A copy of the qualifying credential or license for the qualified supervisor must be attached.

On-the-Job Supervision Requirement	150 hours of direct clinical supervision of the applicant's performance of mental health related services. A minimum of 10 hours of supervision per domain is required in the categories as listed on page 2 of the *On-the-Job Supervision Verification Form*. For certification purposes, the FCB benchmarks reasonable and achievable supervision at the rate of 3 hours per week/156 hours per year. Eligible on-the-job supervision occurred within the last 5 years.

PERFORMANCE DOMAIN CATEGORIES

Minimum of 10 hours must be completed in each performance domain listed below. The remaining hours may be allocated across any category(ies).

ASSESSMENT: Supervision in this domain is the ongoing process through which the counselor collaborates with the client and others to gather and interpret information necessary for planning treatment and evaluating client progress.
PERSON CENTERED SERVICE/RECOVERY PLANNING: Supervision in this domain is the process through which the mental health professional interprets all relevant assessment information in order to begin the development of the individualized plan of care. Recovery planning includes discussing assessment findings with the service recipient and significant others in order to facilitate the development of the plan of care. It involves formulating mutually agreed upon and measurable service/recovery goals as well as appropriate strategies, resources, and outcome indicators to reach desired goals.
COUNSELING: Supervision in this domain involves a collaborative process that facilitates the client's progress towards mutually determined treatment goals and objectives. Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context.
SERVICE COORDINATION: Supervision in this domain is the administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service Coordination includes case management and client advocacy, and establishes a framework of action for the client to achieve specified goals.
PROFESSIONAL RESPONSIBILITY AND ETHICS: Supervision in this domain is the obligation of a mental health professional to adhere to accepted ethical and behavioral standards of conduct and continuing professional development.

SUPERVISOR REQUIRED DOCUMENTATION

A qualified supervisor must maintain documentation of supervision, copies of which may be requested by Certification Staff at any time. Documentation must include the following minimum information:

a. Supervisee name, current position and credential sought.
b. Date of supervision, start and end time of supervision, and number of supervision hours accrued.
c. Supervisor name and title.
d. Methods of supervision (individual, group, observation, review clinical documentation).
e. Summary of supervision offered during session.
f. Signature of both Supervisee and Supervisor

Documentation does not need to be submitted with this verification form. FCB has supervision documentation templates posted online that may be used if needed.

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All information must be typed. Handwritten forms will be denied.

Part 1: To be completed by the applicant prior to providing to the qualified supervisor for completion.

Applicant Information: Please list the position you held for which you are requesting documentation of on-the-job supervision by a qualified supervisor. Report employment dates in the following format: MM/DD/YYYY to MM/DD/YYYY. Use a separate form for each qualified supervisor documenting one-on-one on-the-job supervision.
Applicant Name:
Employer:
Type of Position: Full-Time Part-Time
Position Title:
Immediate Supervisor:

Part 2: To be completed by the applicant's qualified supervisor only.

Section A: Qualified Supervisor Contact Information	
Last Name:	**First Name:**
Title:	**Employer:**
Email Address:	**Business Phone:**
Work Address:	
City:	**State:**
Zip Code:	**County:**

Section B: Supervision Attestation

I am a qualified supervisor because I am:

A physician or physician's assistant licensed under Chapters 458 or 459, F.S.

A professional licensed under Chapters 490 or 491, F.S.

A Psychiatric Advanced Registered Nurse Practitioner licensed under Part 1 of Chapter 464, F.S. and meeting the Board of Nursing requirements for a Psychiatric ARNP designation.

A MCAP or CAP credentialed through the Florida Certification Board.

A CMHP with a Master's Degree.

Copy of qualifying credential or license for the qualified supervisor is attached. ❒ *Yes* ❒ *No*

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Section B: Supervision Attestation Continued		
Domain Category – ***Please see Page 2 of On-the-Job Supervision Verification Form for instructions***	**Individual Supervision Number of Hours**	**Group Supervision Number of Hours**
ASSESSMENT		
PERSON CENTERED SERVICE/RECOVERY PLANNING		
COUNSELING		
SERVICE COORDINATION		
PROFESSIONAL RESPONSIBILITY AND ETHICS		
TOTAL HOURS PER CATEGORY:		
TOTAL HOURS OF ON-THE-JOB SUPERVISION EARNED: **(No more than 50% of the total required hours may be in a group setting)**		

Type of Position Supervised	❒ Full-Time ❒ Part-Time	Time period during which supervision was provided: From: To:

I have read and understand the on-the-job supervision requirements for Certified Mental Health Professional (CMHP) certification. I provided the above on-the-job supervision to the applicant and maintain supervision records supporting my attestation according to agency protocol. I consent to an audit of such records if requested.

❒ Yes ❒ No

As a qualified supervisor, do you have any concerns about the applicant's ability to competently perform as a Certified Mental Health Professional? ❒ Yes* ❒ No

*If yes, the FCB will contact you for additional information, which may result in non-acceptance of your on-the-job supervision to meet certification requirements.

I provided on-the-job supervision of the applicant as he or she performed mental health related duties at the level expected of a CMHP. ❒ Yes ❒ No

By my signature, I attest that the above material is true to the best of my knowledge.

Qualified Supervisor's Signature *(FCB accepts manual and electronic signatures)* **Date**