Postdoctoral Supervision Documentation

This document is primary source verified. It is to be completed by the Supervising Licensed Psychologist or Medical Psychologist and returned directly to the LSBEP at 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. This document will not be accepted if sent by the applicant.

Supervisee:_____

Educational level: _____

Area of specialization:_____

Supervisor:_____

Title: _____ Area of specialization: _____

Address: _____ Office phone number: _____

_____ License number: _____

_____ State granted: _____

Name of setting:_____

Nature of setting:_____

Dates of practice covered in this report: From _____ (mm/dd/yyyy) To _____ (mm/dd/yyyy)

Total Number of practice hours: _____ Number of months: _____

Total number of one-to-one general/professional supervised hours per wk: _____

Total number of one-to-one specific case discussion/skill training per wk: _____

Total number of supervised hours:_____

Supervisee's duties: _____

_____

_____

Assessment of supervisee's performance:_____

_____

_____

_____

_____

Are there any areas of practice that are beyond this applicant's competence or experience?_____ If so, please explain:_____

_____

_____

_____

If you were a member of this licensing board, would you have any reservations about granting this applicant a license? _____ If so, please explain: _____

_____

_____

_____

Signature of Supervisor _____Date _____

Rev. 02/16