



COLORADO

Department of
Regulatory Agencies

Division of Professions and Occupations

Management Branch
Office of Licensing

**POST-DEGREE EXPERIENCE AND SUPERVISION—Licensed Professional Counselor
INSTRUCTIONS/CHECKLIST**

- Keep originals and upload ONE form for EACH supervisor and place of employment.
- All fields must be completed.
- Original signatures are required.
- The supervisor MUST initial ANY corrections to the form(s), including white-outs and crossed out information.
- Signatures cannot be dated prior to the last date of experience/supervision.
- The supervisor must be or have been licensed in the state in which the supervision took place during the time of supervision.
- Experience and supervision hours must be completed after the date all degree requirements have been met. If you completed all degree requirements prior to the conferral date posted on your transcript and wish to begin counting your post-degree supervised experience from the earlier date, the Department Chair or a staff member of similar status must provide a letter verifying the date you met all requirements for the specific degree awarded.
- Once all hours have been completed, upload all Post-Degree Experience and Supervision form(s) together at the time of your online application.
- Experience and supervision must be done concurrently.

Experience:

- 2,000 clock hours must be documented over a **minimum** of 24 months.

Supervision:

- Supervision is defined in the Board of Licensed Professional Counselor Examiners Rules, Licensure by Examination. You may review the rules on the Laws, Rules and Policies webpage: colorado.gov/dora/Professional_Counselor_Laws.
- Applicants must receive a minimum of 100 clock hours of supervision, at least 70 hours of which must be face-to-face individual supervision, over a **minimum** of 24 months.



COMPLETED POST-DEGREE EXPERIENCE AND SUPERVISION—Licensed Professional Counselor – Clinically Supervised Work Experience

SECTION 1: To be completed by the APPLICANT

Applicant Name: First:	Middle:	Last:	Suffix:
Place of Employment:			
Employment Address:	PO Box, Street:		
	City, State, Zip:		

SECTION 2: To be completed by the CLINICAL SUPERVISOR

The information listed below must reflect only those post-degree activities and services the applicant performed under the supervisor's "personal direction and responsible direction" (see the Board of Licensed Professional Counselor Examiners Rules, Licensure by Examination, and the Colorado Mental Health Statute, section 12-43-601, C.R.S., for applicable rules and definitions). Experience and supervision must be done concurrently.

EXPERIENCE and SUPERVISION was conducted and completed between

_____ and _____ as follows:
(mm/dd/yyyy) (mm/dd/yyyy)

EXPERIENCE 2,000 clock hours over a <u>minimum</u> of 24 months	SUPERVISION 100 clock hours, with at least 70 hours of face-to-face/individual supervision, over a <u>minimum</u> of 24 months
(a) _____ work experience hours	(a) _____ hours of face-to-face/individual supervision
Does this experience include teaching? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES :	(b) _____ hours of group supervision
(b) _____ teaching hours included in (a) above. Attach a description of the courses taught.	
_____ TOTAL HOURS of post-degree experience.	_____ TOTAL HOURS of post-degree supervision

I affirm that the experience and supervision I have described on this form was conducted and completed in accordance with Title 12, Article 43, Colorado Revised Statutes and the Board of Licensed Professional Counselor Examiners Rules, Licensure by Examination. I further affirm that the supervisee's work toward the hours of experience was conducted and completed under my supervision, and has met the generally accepted standards of practice.

I declare under penalty of perjury in the second degree that the statements made in this application are true and complete to the best of my knowledge. In accordance with section 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law and may constitute violation of the practice act.

Supervisor Name: (print)		Degree:		
Address: PO Box, Street:				
City, State, Zip:				
State where experience / supervision took place	Type of license	License Number	License Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

Supervisor Signature: _____ **Date:** _____

Applicant Signature: _____ **Date:** _____

