

Wybrane dokumenty superwizji Stanu Alabama (USA)



THE  
ALABAMA  
STATE  
BOARD OF  
SOCIAL  
WORK  
EXAMINERS

**CONTRACT FOR SUPERVISION**

Must be submitted for approval by the Board: ABSWE, PO Box 301620, Montgomery, AL 36130-1620

Supervisee: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First Middle/Maiden

License Number: \_\_\_\_\_ License Level: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Employment Address: \_\_\_\_\_  
Street Address City State Zip

Supervisor: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First Middle/Maiden

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Employment Address: \_\_\_\_\_  
Street Address City State Zip

License Number: \_\_\_\_\_ License Level: \_\_\_\_\_ PIP#: \_\_\_\_\_

Is this Supervision within the Agency? Yes \_\_\_ No \_\_\_ Registered as Supervisor: Yes \_\_\_ No \_\_\_

Dates of Supervision: From \_\_\_\_\_ to \_\_\_\_\_

It is understood that a minimum of four hours per month of face-to-face supervision is required for 24 months within a 36 month period for Social Work Licensure.

Method of supervision: Group: \_\_\_ Individual: \_\_\_ Combination: \_\_\_

Practice supervised: Clinical: \_\_\_ Casework: \_\_\_ Administration: \_\_\_ Community Org.: \_\_\_ Research: \_\_\_

If supervision is provided under contract with a PIP, the cost of the supervision is \_\_\_\_\_ per hour, payable monthly after supervision for that month is completed. Payment of the supervision is the responsibility of \_\_\_\_\_.

The supervisor agrees to adhere to the confidentiality policies of the Supervisee's employing agency.

It is agreed that written evaluations will be completed by the supervisor, using the approved evaluation form at the end of the 12<sup>th</sup> and 24<sup>th</sup> month of the supervisory period. A copy of the evaluation form will be given to the supervisee, the original submitted to the Board, and a copy maintained by the supervisor. It is agreed that if either party terminates this contract, the supervisor will promptly complete the evaluation and termination forms and submit them to the Board. The undersigned agree to adhere to the guidelines on supervision.

Supervisee's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

ALABAMA STATE BOARD OF SOCIAL WORK EXAMINERS:

Approved: \_\_\_\_\_ Disapproved: (attach explanation) \_\_\_\_\_ Date: \_\_\_\_\_



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**Evaluation for Social Work Licensure**

Evaluation Period: Twelve Months \_\_\_\_\_ Twenty-four Months \_\_\_\_\_ Other \_\_\_\_\_ Termination \_\_\_\_\_

Supervisee: \_\_\_\_\_ License #: \_\_\_\_\_ SSN \_\_\_\_\_

Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_ SSN \_\_\_\_\_

Dates of Supervision: From: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Average monthly supervision hours: \_\_\_\_\_ Total hours: \_\_\_\_\_

Practice Supervised: Clinical \_\_\_\_\_ Casework \_\_\_\_\_ Adm. \_\_\_\_\_ Comm. Org. \_\_\_\_\_ Research \_\_\_\_\_

Reason for termination, if applicable: \_\_\_\_\_

Please rate the licensee on the following practice characteristics. Place a mark in every category.

| CHARACTERISTICS                       | SATISFACTORY | UNSATISFACTORY | N/A |
|---------------------------------------|--------------|----------------|-----|
| Individual Counseling Skills          |              |                |     |
| Appropriate Referral Making           |              |                |     |
| Group Counseling Skills               |              |                |     |
| Personal Integrity                    |              |                |     |
| Consulting Skills                     |              |                |     |
| Insight Into Client's Problems        |              |                |     |
| Ability to Work with Co-Workers       |              |                |     |
| Ability to Relate to Co-Workers       |              |                |     |
| Ability to be Objective on the Job    |              |                |     |
| Ethical Conduct                       |              |                |     |
| Concern for the Welfare of Clients    |              |                |     |
| Sense of Responsibility               |              |                |     |
| Recognition of Own Limits             |              |                |     |
| Ability to Keep Material Confidential |              |                |     |

Explain any rating of "Unsatisfactory" and any additional comments on a separate sheet and attach to this form.

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

This Evaluation has been discussed with me and I have received a copy of it.

Signature of Supervisee: \_\_\_\_\_ Date: \_\_\_\_\_

The original of this form must be mailed to:

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### TERMINATION OF SUPERVISION

Supervisor: \_\_\_\_\_ certify that I supervised

Supervisee: \_\_\_\_\_

in the field of Social Work while he/she was employed at \_\_\_\_\_  
Agency

Dates of Supervision: From \_\_\_\_\_ to \_\_\_\_\_.

I provided \_\_\_\_\_ hours of supervision per month for a total of \_\_\_\_\_ hours of supervision.

Supervision was provided in the social work methods of (check as appropriate):

\_\_\_\_ Social Casework      \_\_\_\_ Social Work Research      \_\_\_\_ Administration  
\_\_\_\_ Community Organization      \_\_\_\_ Clinical      \_\_\_\_ Other (specify)

Reason for termination of supervision: \_\_\_\_\_

**Attach evaluation for Social Work Licensure**

Name of Supervisor \_\_\_\_\_ Telephone \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_\_

The termination of supervision has been discussed with me, and I have received a copy of this form.

Signature of Supervisee \_\_\_\_\_ Date \_\_\_\_\_

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