



LOUISIANA LICENSED PROFESSIONAL  
COUNSELORS BOARD OF EXAMINERS  
MARRIAGE AND FAMILY THERAPY ADVISORY COMMITTEE

**PLMFT CHANGE/ADD Supervisor Application**  
**(For Approved PLMFTs ONLY)**

**General Instructions:**

- If in the course of your provisional licensure as PLMFT you change or add a supervisor, you must complete the Provisional Licensed Marriage and Family Therapist (PLMFT) Change/Add of Supervisor Application. This application must be completed and approved by the Board before you may begin accruing supervised experience hours with your new Board-Approved Supervisor.
- A non-refundable fee of \$50 must accompany submission of the PLMFT Change/Add of Supervisor Application to the Board.
- An updated copy of your Statement of Practices and Procedures must be submitted with this Application. Guidelines for writing your Statement of Practices and Procedures (SOP) and a sample SOP are available on the Board website.
- If you are **changing supervisors**, you must submit a **Documentation of Experience (DOE) form completed by your current Board-Approved Supervisor**.
- Please be advised, you must continue supervision with your current Board-Approved Supervisor until a new supervisor is approved by the Board. If you discontinue supervision with your current Board-Approved Supervisor before you are approved to either change or add another supervisor, **you must cease counseling** until a new supervisor is approved by the Board.
- Please note that when making inquiries to the Board, staff members are **unable to pre-approve any applications**. Please consult the Board's website to obtain any applicable laws/rules in answering your inquiries. Official inquiries to the Board may be made in writing via email or regular mail.



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**Applicant Information:**

Applicant's Name: \_\_\_\_\_  
(First) (Middle/Maiden) (Last)

Home Address: \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City/State) (Zip Code)

Telephone: \_\_\_\_\_  
(Home) (Work) (Cell)

Email: \_\_\_\_\_  
Would you like this email address to be listed on the website? Yes  No

Address you prefer to be used for all mail correspondence:  Home  Work

Address you prefer to be placed on the LPC Board Website:  Home  Work  None

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo to a crime (felony or misdemeanor) in any court, excluding minor traffic violations? Yes  No

2. Do you have any pending legal charges, which may affect your status as a PLMFT? Yes  No

3. Have you had a professional license, registration and/or certificate in any state to be voluntarily or involuntarily relinquished, restricted, revoked, suspended, or denied? Yes  No

4. Have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? Yes  No

5. Have you used or are you currently using any narcotics, controlled substances, or any alcoholic beverage in a manner that is dangerous to the public or in a manner that impairs your ability to provide mental health services to the public? Yes  No

6. Do you have a medical condition which may in any way impair or limit your ability to practice professional counseling or therapy with reasonable skill and safety? Yes  No

**If you have answered yes to any of the above, please attach a separate sheet with a notarized explanation including dates, charges, court or regulatory authority, and an explanation of the situation including documentation of successful resolution of the charges and/or proof of felony expungement (if applicable).**

**Board-Approved Supervisor Information**

**Please Select One:** I am changing supervisors.

I am adding an additional supervisor.

Other \_\_\_\_\_

**Board-Approved Supervisor Information:**

LMFT-S/SC's Name: \_\_\_\_\_  
(First) (Middle/Maiden) (Last)

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

Work Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_ (City/State) (Zip Code)

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell)

Email: \_\_\_\_\_

**Is the Supervisor a relative of the applicant?** Yes  No

**If yes, please state relationship:** \_\_\_\_\_

**Plan-of-Supervision:**

- The Plan of Supervision is a written agreement that establishes the supervisory framework for the PLMFT's postgraduate clinical experience and describes the expectations and responsibilities of the supervisor and the supervisee.
- The supervisor and the supervisee must discuss the expectations and responsibilities of each party and complete the remainder of this form.
- If a PLMFT has more than one approved supervisor, this form must be completed for all approved supervisors.

Date upon which supervision is to begin: \_\_\_\_\_

Expected date of conclusion of supervision: \_\_\_\_\_

Location where Supervision will be Conducted (Please check all that apply):

- Supervisor's Office
- Supervisee's Practice Setting
- Other (Please specify): \_\_\_\_\_

Frequency of Face-to-Face Supervision with Supervisor:

- Weekly
- Every Other Week
- Other (Specify) \_\_\_\_\_

What is the duration of a typical supervision session? \_\_\_\_\_

Type of Face-to-Face Supervision that will be utilized (Check all that apply):

- Individual Supervision (Supervision of 1 or 2 supervisees by one supervisor)  
Expected Frequency: \_\_\_\_\_
- Group Supervision (Supervision of up to 6 supervisees regardless of the number of supervisors present)  
Expected Frequency: \_\_\_\_\_
- Co-Therapy Supervision (Supervision outside of the session in which the supervisor acts as a co-therapist)  
Expected Frequency: \_\_\_\_\_
- Synchronous Videoconferencing  
Expected Frequency: \_\_\_\_\_

Indicate the content areas for supervision that have been discussed and agreed upon by both supervisor and supervisee:

<b>Content Area</b>	<b>Yes</b>	<b>No</b>
1. The role and responsibilities of the supervisor and supervisee in the supervision process.	<input type="checkbox"/>	<input type="checkbox"/>
2. The supervisor's style of supervision.	<input type="checkbox"/>	<input type="checkbox"/>

3. The agreed upon theoretical orientation for the supervision.
4. How confidentiality will be maintained and limits of confidentiality.
5. Confidentiality issues and coordination involved in working with any other clinical and/or administrative supervisors who might be involved in the practice setting.
6. Any issues, rules, regulations specific to institution/agency in which therapy and/or supervision will be conducted such as rules on video/audio taping, removal of case records, etc.
7. How feedback will be provided to one another.
8. How learning objectives will be established and how those objectives will be changed if needed.
9. Evaluation procedures including when formal evaluations will take place, how the evaluations will be documented, and what criteria will be used in the evaluation process.
10. How impasses/blocks/disagreements will be handled and the procedure if either supervisor or supervisee decide to terminate the supervisory relationship.
11. Reporting requirements and emergency procedures for high-risk or abusive clients.
12. Procedure the supervisee will take in case of emergencies, including the first step the supervisee needs to take, how the supervisee can reach the supervisor, mandated reporting, etc.
13. The required ethical code(s) of the supervisor and the supervisee, including what codes besides the Code of Conduct for Licensed Professional Counselors in Louisiana the supervisee must abide by and what to do if these ethical codes differ.
14. Record keeping, including how records of supervision will be kept, both session noted and log of supervision.
15. Use of Statement of Practices and Procedures.

Please add any information that has not been covered which you believe is important to this plan of supervision.

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## PLMFT Practice Setting Information

### Practice Setting/Place of Employment:

- Please complete the following for the setting(s) in which you will complete your supervised experience hours. You may attach an additional sheet if necessary. Please be advised that you may not practice independently as a PLMFT unless you are licensed to practice by another mental health discipline.

- **Please Indicate Type of Setting:**

- |   |  |
|---|--|
| <input type="checkbox"/> Community Behavioral Health Center | <input type="checkbox"/> Hospital              |
| <input type="checkbox"/> Private Practice                   | <input type="checkbox"/> Rehabilitation Center |
| <input type="checkbox"/> School                             | <input type="checkbox"/> University/College    |
| <input type="checkbox"/> Other _____                        |  |

Name of Setting: \_\_\_\_\_

Address of Setting: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City/State) (Zip Code)

Initial Employment Date: \_\_\_\_\_

Job Title at time of Initial Employment Date: \_\_\_\_\_

Job Duties at time of Initial Employment Date: \_\_\_\_\_

Will your Title at setting change if approved as PLMFT? Yes  No

If yes, please provide Proposed Title: \_\_\_\_\_

Will your Duties at setting change if approved as PLMFT? Yes  No

If yes, please provide Proposed Duties: \_\_\_\_\_

Total hours per week applicant will be working: \_\_\_\_\_

Anticipated date for completion of required supervised hours: \_\_\_\_\_

Name, Title, Credentials, and Email Address of **Administrative** Supervisor:

\_\_\_\_\_

Identify any individuals who have an ownership interest in the practice setting, including degree and licensure information.

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Describe briefly the nature of the practice setting where your supervised experience (direct and indirect client contact) will take place. If available, please include any literature such as a brochure, pamphlet, or other written information with your application.

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Describe the nature of the duties to be performed. Please include types of cases, age range of clients, nature of presenting problems, and any other information regarding the population served which may be pertinent.

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Describe the type of assessment procedures to be utilized, therapeutic approaches to be employed, and typical interventions, which may be utilized. **PLMFTs should apply systemic theories and treatment with all clients and make every effort to work with as many couples and families as possible.**

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Describe the nature of the supervision with your Board-Approved Supervisor. Will the supervisor review tapes, applicant's case notes, use group sessions with other professionals, seminars, etc.?

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**Attestation of PLMFT:**

With my signature below, I attest that the information provided in this application is correct. I will adhere to the requirements regarding supervised counseling experience as stated in Chapter 33, Sections 3315 and 3319 of the Board Rules. I further understand that as a PLMFT, I may not practice independently unless I am licensed to do so in another mental health discipline. I am aware that I must receive active supervision (as defined in Chapter 31, Section 3105 of the Board Rules) approved by the Licensed Professional Counselors Board of Examiners, through the Marriage and Family Therapy Advisory Committee, until I have successfully completed all the training requirements and have been fully licensed as a LMFT. I understand that the minimum acceptable supervised experience shall be 3000 hours, obtained in no less than 2 years and in no more than 6 years. 2000 of the 3000 hours must consist of direct service to clients. I understand that I must notify the Board and my Board-approved LMFT-S/LMFT-SC of any practice setting changes, including address and phone number changes, by submitting the PLMFT Change of Practice Setting Application and updated Statement of Practices and Procedures to the Board; or be subject to **a fine and forfeiture of accrued supervision hours at such setting**. I certify that I have read and am familiar with the Code of Ethics and standards of practice of the Louisiana LPC Board.

\_\_\_\_\_  
Signature of PLMFT

\_\_\_\_\_  
Printed Name of PLMFT

\_\_\_\_\_  
Date

**Attestation of Board-Approved LMFT Supervisor/Supervisor Candidate:**

I have reviewed this proposal for supervised experience and accept this applicant and agree to supervise this applicant at the above described practice setting, I will adhere to the requirements regarding my role as a Board-Approved Supervisor/Supervisor Candidate in Chapter 33, Section 3321 of the Board Rules. I understand that a PLMFT must remain under the active supervision (as defined in Chapter 31, Section 3105 of the Board Rules) of their Board-Approved LMFT-S/LMFT-SC until fully licensed as a LMFT, even after the completion of the minimum supervised experience requirements. If my supervision of this PLMFT terminates for any reason, I will inform the Licensed Professional Counselors Board of Examiners in writing and submit all required paperwork in a timely manner.

\_\_\_\_\_  
Signature of LMFT Board-Approved Supervisor/Supervisor Candidate

\_\_\_\_\_  
Printed Name of LMFT Board-Approved Supervisor/Supervisor Candidate

\_\_\_\_\_  
Date