SEQUEL CARE OF ARIZONA CLINICAL SUPERVISION SESSION FORM

Name of Supervisee:	*Mode of clinical Supervision* __ *Online* __ *Telemedicine* __ *In person* __ *Telephone* *Please Indicate:* __ *Individual* __ *Group(2)* __ *Group (3-6)*
Date of Session:	Duration of session: *(Sessions must be at least 30 minutes)*
Comprehensive description of topics discussed:	
Comprehensive description of results of compliance review of supervisee's clinical documentation:	
Trainings provided:	
Does any conflict of interest exist between supervisor and supervisee? __ Yes __ No	
Does any conflict of interest exist between supervisor and clients? __ Yes __ No	

All sections above must be completed in their entirety. Refer to R4-6-212 C-D.

Supervisor's name and credentials: _____

Supervisor's telephone number: _____

_____ _____

Supervisor Signature *Date signed*

_____ _____

Supervisee Signature *Date signed*

Clinical Supervision form effective 11/01/15