COUNSELOR ASSISTANT SUPERVISION LOG

DATE OF SUPERVISION			**LENGTH OF SUPERVISION SESSION**	
DATE OF LAST SUPERVISION			**2 hours supervision for 20 hours or more OR 1 hour supervision for 19 hours or less of services supplied per month**	

COUNSELOR ASSISTANT

NAME	SIGNATURE	CREDENTIAL	JOB TITLE

SUPERVISING COUNSELOR

NAME	SIGNATURE	CREDENTIAL	JOB TITLE

REVIEW OF COUNSELOR ASSISTANT WORK PERFORMANCE PER TAP 21

FOCUS AREAS(S)	NOTES

REVIEW OF UNIQUE TREATMENT NEEDS OF CLIENTS

COUNSELOR ASSISTANT PROGRESS TOWARD GOALS

GOAL	PROGRESS

ADDITIONAL TRAINING NEEDS IF IDENTIFIED

WHAT	HOW	WHEN

COUNSELOR ASSISTANT EVALUATION OF RELEVANCE OF SUPERVISION

_____ _____

Counselor Assistant Date Supervisor Date

DISTRIBUTION: Original: Employee file Copies to: Assistant Counselor, Supervising Counselor, Program Director, Dir. Of Program Development