Mental Health and Recovery Services
Quality Management Services

Clinical Supervision Reporting Form

Form Type

☐ NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to QMS/MCST.

Registered/Waivered Supervisee Information (select all that apply)

☐ County Employee
or
☐ Contract Employee

☐ Adult and Older Adult [AOA]
☐ Children and Youth Prevention [CYP]
☐ Drug Medi-Cal Organized Delivery System [DMC-ODS]

Name:

Registration Type: Select Registration Type Registration #:

DHCS Professional Licensing Waiver [Registered/Waivered Psychologist ONLY] ☐ YES ☐ NO **IF YES, THE DHCS PROFESSIONAL LICENSING WAIVER FORM IS REQUIRED TO BE SUBMITTED TO MCST.**

Phone: Email:

Program/Clinic:

Service Chief/Program Director:

Clinical Supervisor Information

Name:

ARE YOU, PROVIDING SUPERVISION FOR A SUPERVISEE OUTSIDE OF YOUR EMPLOYER? IF YES, SUBMIT THE WRITTEN OVERSIGHT AGREEMENT. ☐ YES ☐ NO

License Type: Select License Type License #:

Phone: Email:

Program/Clinic:

Service Chief/Program Director:

Supervision Term

Start Date: End Date:

If terminating clinical supervision, complete this section:

Reason for termination: ☐ Licensed ☐ Change of Supervisor ☐ Termination of Employment ☐ Other

- If changing clinical supervisor, additionally submit required document(s) for new clinical supervisor
- If licensed, date of promotion per HR:
- If terminating employment, date of termination:
- If other, please specify:

CHECKLIST OF DOCUMENTS REQUIRED TO SUBMIT TO MCST:

☐ Supervisor Self-Assessment Report Form ☐ Supervision Agreement Form (Replaced the Supervisory Plan & Supervisor Responsibility Statement)
☐ Written Oversight Agreement (if applicable)
☐ Request for Live-Scan Service Form for the BBS 90-Day Rule (County-Contracted only – if applicable)
☐ DHCS Mental Health Professional Licensing Waiver Request (Psychologist only)

I certify that I understand the responsibilities regarding clinical supervision and that the clinical supervision provided meets the requirements as specified by the Board. I attest that the information submitted on this form is true and correct:

Registered/Waivered Supervisee Signature Date

Licensed Clinical Supervisor Signature Date

*Please complete in full and submit to: AQISManagedCare@ochca.com. For questions, please contact QMS main line: 714-834-5601.