



SUD Counselor Supervision Reporting Form

STATUS TYPE

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

SUPERVISEE INFORMATION (select all that apply)

County Employee

Adult and Older Adult [AOA]

Children and Youth Services [CYS]

Contract Employee

Drug Medi-Cal Organized Delivery System [DMC-ODS]

Name:

NPI #:

Registration Type:

Phone #:

Registration #:

Email:

Program/Clinic:

Service Chief/Program Director:

SUPERVISOR INFORMATION

Name:

NPI #:

License/Certification Type:

Phone #:

License/Certification #:

Email:

Program/Clinic:

Service Chief/Program Director:

SUPERVISION TERM:

Start Date:

End Date:

REASON FOR TERMINATING SUPERVISION:

Termination of Employment (enter date of separation):

Change of Supervisor

Became Certified (enter date of certification):

Other, please specify:

I certify that I understand the responsibilities regarding supervision. I attest that the supervision and the supervisor meet the requirements as specified by the certifying and or licensing organization. I acknowledge that the information submitted on this form is true and correct.

Registered Supervisee Signature

Date

Licensed/Certified Supervisor Signature

Date

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