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Governor

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Training Plan Amendment – New/Additional Work Site Addiction Counseling

This form should only be used if you have an approved training plan on file with the BSRB and you have changed work sites or are adding an additional work site.

I. Information regarding supervisee:

Name _____ LAC/LMAC Number _____
Home Address _____
City, State, Zip _____
Home Phone _____ Cell Phone _____ (Optional)
Email _____

II. Information regarding the new/additional employment site:

A. Submit the supervisee's official position description, for this work site, with the amendment.

B. Is this a new work site or an additional work site? _____

C. End date of employment from previously approved training plan work site: _____

D. Date new/additional employment began: _____

E. Name of Agency and address where the supervisee will be accruing hours towards the LCAC

Agency _____

Address _____

City, State, Zip _____ Phone _____

Title of supervisee's position in this supervised setting _____

Will you be working at any time outside the State of Kansas? Yes _____ No _____

If yes, is your clinical supervisor clinically licensed in the state in which you will be working? Yes _____ No _____

F. Will the supervisee be involved in the process of diagnosing clients? Yes _____ No _____

****If answer is yes, please describe how. ****

G. Will the supervisee, under the direction of the supervisor, be providing psychotherapy to the clients?
**If answer is yes, please describe how. Yes_____ No_____

III. Information regarding supervisor:

A. Name of your clinical supervisor: _____

B. Is this a previously approved supervisor for your clinical training plan? Yes_____ No_____

If “NO,” you will also need to complete the Training Plan Amendment form for a new supervisor.

Answer the following questions on a separate sheet of paper:

1. Will the supervisee be using the DSM V in diagnosing clients?
2. Please list some specific diagnoses the supervisee is expected to treat.
3. What are the anticipated types of clients to whom the supervisee will be providing services?
4. What services will the supervisee be providing to clients?
5. What are some theories of psychotherapy the supervisee plans to use in treating clients?
6. Describe the plan for notifying the clients that the supervisee is practicing under supervision, the limits of confidentiality under supervision, and the name and contact information for the supervisor.
7. Please provide any additional changes on a separate sheet of paper.

V. Supervisor’s and Supervisee’s Attestation

We, the undersigned supervisee and supervisor, acknowledge that we have both read and agree to all aspects of this amended training plan, and have read and understand the post graduate supervised work experience requirements set forth in regulations. We attest, to the best of our knowledge, that this plan meets the training requirements as outlined in statute and regulation, including the requirements for the provision of psychotherapy and assessment as well as the required supervision. We also attest that the forgoing information constitutes an accurate and honest description of the duties to be performed by the supervisee.

Additionally, the supervisee hereby gives consent to the supervisor to discuss supervision or performance issues with the supervisee’s clients, other professionals in the practice setting, the Board, or any other individual to whom either is professionally accountable.

Signature of Supervisor	Date	Signature of Supervisee	Date
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You should receive a written response regarding your clinical training plan amendment from the board office within 30 days. If you have not received a response within 30 days from submission, please contact the board office.

Attention supervisors, for additional information regarding clinical supervision, please see the website at: www.ksbsrb.ks.gov