

## Training Plan Amendment – New/Additional Work Site Professional Counselors

This form should only be used if you have an approved training plan on file with the BSRB and you have changed work sites, are adding an additional work site, or you are notifying the Board of any change to an approved work site, for example a change in position at a previously approved site.

Return the amendment to the BSRB by postal mail to the address above or by email to [bsrb@ks.gov](mailto:bsrb@ks.gov) Do not submit the training plan by fax.

### 1. Information regarding supervisee:

Name \_\_\_\_\_ LPC Number \_\_\_\_\_  
Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
(Optional)

### 2. Information regarding the supervision setting:

- A. Submit the supervisee's official position description, for this work site with the amendment.
- B. Indicate if this is this a new or additional work site or a change to an approved work site \_\_\_\_\_
- C. If a change, describe the change. \_\_\_\_\_
- D. End date of employment from previously approved work site: \_\_\_\_\_
- E. Date new/additional or employment change began \_\_\_\_\_
- F. Name of Agency and address where supervisee will be accruing hours towards the LCPC

Agency \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Title of supervisee's position in this supervised setting \_\_\_\_\_

Will the supervisee be providing services to clients who are not physically located in the state of Kansas?

Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, is the supervisee licensed in the state where the client is located? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is the clinical supervisor licensed in the state where the clients are located? Yes \_\_\_\_\_ No \_\_\_\_\_

G. Will the supervisee be involved in the process of diagnosing clients? Yes \_\_\_\_\_ No \_\_\_\_\_

H. Will the supervisee, under the direction of the supervisor, be providing psychotherapy to the clients? Yes \_\_\_\_\_ No \_\_\_\_\_

**3. Information regarding supervisor:**

- A. Name of your clinical supervisor: \_\_\_\_\_
- B. Clinical supervisor contact information (email and phone) \_\_\_\_\_
- C. Is this your previously approved supervisor for your clinical training plan? Yes \_\_\_\_\_ No \_\_\_\_\_  
If “NO,” you must also complete the Training Plan Amendment form for a new supervisor.

**Please provide answers to the following questions on a separate sheet of paper:**

1. Will the supervisee be using the DSM-5 in diagnosing clients?
2. Please list some specific diagnosis 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.

**4 Supervisors and Supervisees 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 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: [ksbsrb.ks.gov](http://ksbsrb.ks.gov)**