

WCSPP TREATMENT SERVICE
COMPLETION OF SUPERVISION
and RECORD REQUIREMENTS
Child and Adolescent Program

Candidate Name: _____ Supervisor Name: _____

I have completed one of my required forty-hour blocks of supervision. During the course of that supervision, my training patient attended sessions at the required frequency for at **least 30 of the 40 session supervisory unit.**

Signature of Candidate: _____

Signature of Supervisor: _____

Date: _____

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My Treatment Service forms are up-to-date and all patient fees have been paid.

Checklist of Forms

1. Screening Report
2. Notification of Start of Treatment
3. Monthly Fee Payment Record – due at the end of each month
4. Treatment Progress Report – due 20th supervisory session
5. Treatment Progress Report – due 40th supervisory session
6. Termination Summary – if applicable

Signature of Candidate: _____

Signature of Supervisor: _____

Date: _____

SUBMIT FORM TO: WCSPP, Nancy Bobker, 260 Stuyvesant Avenue, Rye, NY 10580