LEWIS & CLARK
GRADUATE SCHOOL OF EDUCATION AND COUNSELING
DEPARTMENT OF COUNSELING, THERAPY, AND SCHOOL PSYCHOLOGY
ART THERAPY PROGRAM

Supervision Summary

Student name: __________________________ Supervisor Name: __________________________________

Date: ______________________ Site: ____

Note: Weekly 1:1 supervision is required to discuss cases, program expectations, documentation, assessments, treatment plans, and ethics as well as any problems which need to be addressed.

Hours	Beginning Date: Ending Date:	YTD Totals
Total Site Hours		
Art Therapy Contact Hours		
Supervision Hours		

Goal/Agenda: (This is to be filled out by student BEFORE supervision meeting)

Weekly Clinical Summary:

Supervision Meeting Notes:

Plan:

____ ____
Student Signature Date Site Supervisor Signature Date