

**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
INDIRECT / Planning / Training / Misc		
DIRECT / Art Therapy Contact Hours (Group, Individual)		
Supervision Hours		
Total Site Hours		

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

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Weekly Clinical Summary:

Supervision Meeting Notes:

Plan:

Student Signature

Date

Site Supervisor Signature

Date