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SUPERVISION APPLICATION

This information will be used to contact you.

Name: _____

Address: _____

Contact Number: _____

Email Address: _____

This information will allow me to identify if your current position applies as clinical work.

Who is your current employer? _____

What is your current position? _____

Please check all that apply for your position.

- | | |
|---|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Psychotherapy | <input type="checkbox"/> Family Therapy |
| <input type="checkbox"/> Other psychosocial-therapeutic interventions | <input type="checkbox"/> Group Therapy |

Does your agency offer clinical supervision hours? _____

If so, what type (circle one): Individual or Group

How many hours are offered? _____

Which license are you seeking? (circle one): LPC LMFT LCSW

Are you or have you already obtained supervision hours? _____

If so, what type (circle one): Individual or Group

If no longer receiving, what was the reason(s) for termination? _____

This information will help me to identify if I would be an appropriate fit for supervision.

Are you planning to work in community health, private practice or both with your license?

Where do you see yourself in five years? _____

What are your plans when you obtain your clinical license? _____

What does your current self-care routine look like? _____

What do you love most about your current position? _____

What is the most challenging about your current position? _____

What have been some challenges for you in the past with supervisors? _____

What do you believe you can benefit from learning from me as your supervisor? _____

What are your goals for supervision? _____

Official Use Only:

**Cover Letter and Resume
Submitted**

- Yes
- No

**Scheduled Time to Meet in
Person:**

- Yes
- No

Met in Person:

- Yes
- No

Results of Consultation: _____

