

PEER SUPERVISION AGREEMENT

This agreement is made by and between the below parties:

Peer Information (Please print):	
Name	
Email	
Phone #	

Supervisor Information (Please print):	
Name	
Email	
Phone #	
Co- Supervisor Information (if applicable):	
Name	
Email	
Phone #	

Place of Practice			
Agency Name		Agency Phone #	
Agency Address		Position Title	
		Hours per week	

This agreement will begin on _____. This agreement will continue until terminated by either party.

Peer agrees to:	Peer Initials	Supervisor agrees to:	Supervisor Initials
Review and abide by the PRSS Code of Ethics		Review SB 69	
Complete all documentation as required		Provide a minimum of individual supervision biweekly	
Meet with supervisor individually biweekly		Observe supervisee with clients quarterly	
Meet with supervisor and other supervisees monthly		Maintain awareness of the supervisee's client caseload	
Document all hours in a way that makes sense for your supervisor and you		Document all supervision hours with the supervisee	
Cease practicing if no longer under supervision		Refrain from engaging in a close personal relationship or friendship with the supervisee	
Other activities as prescribed by supervisor:		Maintain active status of PRSS-S credential by completing all necessary continuing education credits in a timely manner	
		Be available to consult with the Board about the certified supervisee concerning the emotional/mental stability and the professional and ethical conduct of the certified supervisee	
		Other activities as prescribed by agency:	

	YES	NO
Are you employed/contracted at the peer's place of practice with access to client files?		
Have you ever provided treatment services to the peer?		
Number of peers currently under your supervision?		

