Elizabeth Venart, M.Ed., N.C.C., L.P.C., *Licensed Professional Counselor*
1811 Bethlehem Pike, Suite 212-213 • Flourtown, PA 19031 • 215.233.2002

Clinical Supervision – Supervisee Information Sheet

Date: _____

SUPERVISEE INFORMATION

Client Name (Last, First, MI): _____Email: _____

DOB: _____ Home Phone: _____ Cell: _____ Work: _____

Mailing Address: _____

_____

At which number do you prefer I contact you? _____

EMERGENCY CONTACT INFORMATION
Contact Name/Relationship: Address: Phone Number: Secondary Number:

CONSENT FOR CLINICAL SUPERVISION
I consent to work with Elizabeth Venart for the purpose of receiving clinical supervision. If I am seeking supervision for the purposes of obtaining licensure, I understand that it is my responsibility to obtain all relevant information and paperwork necessary for my licensure and to determine for myself the amount of hours – and type of hours- required. By entering into a clinical supervision relationship, I also understand that Elizabeth Venart will be in a position to evaluate the quality of my work and, if I am seeking licensure, she will need to complete paperwork that accurately reflects her assessment of my clinical skills.

Client Name: _____ Signature: _____ Date: _____

48-HOUR CANCELLATION POLICY

I certify the information that I have provided is correct. If I choose to request receipts that I will forward to an employer, I authorize the release of information necessary for the purpose of payment.

I understand that I am required to give at least 48 hours notice before any cancellation. If I do not remember to cancel a session or if I call to cancel but do not give at least 48 hours notice, I understand that I will need to pay the full professional fee for the missed session. This applies to both individual supervision and group supervision.

_____ _____
Client Signature Date