**“No Right to Private Practice” Agreement**

**For those Supervisee that are licensed**

**Statement of Understanding**

The undersigned Supervisee understands that he/she has entered into a clinical supervision agreement which, under law and GA Composite Board of PC, SW, MFT rules, allows him/her to work toward licensure as an Associate Professional Counselor. Until the process is completed and a license is granted by the state of Georgia you are not permitted to practice privately (i.e. receive payments directly from clients for counseling services).

**No Private Practice Allowed**

All work must be supervised and directed by an authorized person/superior or agency. Your employer will provide the direction.

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Superior/Directors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Title of Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a Licensed Associate Professional Counselor, I understand the following: (initial each item)

\_\_\_\_ I may only use the title "Associate Professional Counselor" or “Licensed Associate Professional Counselor” in all documentation, including the informed consent, business cards, etc.

\_\_\_\_ I may not go into private practice, even though I am under clinical supervision.

\_\_\_\_ I may engage in the practice of Professional Counseling, but only under direction and supervision.

\_\_\_\_ My worksite is listed on the “Contract Affidavit” and if I change employment or directors, I will update the “Contract Affidavit” and send to the Ga Composite board within the required two-week period.

\_\_\_\_ I cannot receive money directly from a client. All compensation I receive must come to me through my employer. My signature below implies that I understand and agree to abide by this provision of the Ga Composite Board.

\_\_\_\_ Failure to follow the above mentioned guidelines will constitute an ethical violation according to Ga Composite Board rules and will be grounds for termination of clinical supervision and the filing of a complaint with the Ga Composite Board as required by the Ethics rule 135-7.

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**Supervisee Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Supervisee Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Clinical Supervisor Signature Date