NORTH DAKOTA BOARD
OF
ADDICTION COUNSELING EXAMINERS

NDBACE

NOTICE:
All NDBACE files are subject to the North Dakota Open Records Law
RETURN FORM TO:
North Dakota Board of Addiction Counseling Examiners
P. O. Box 1053
Bismarck, ND 58502
board@ndbace.org

Supervision Plan for LMAC

An applicant must provide evidence of having earned 2,000 hours of clinical experience as an LAC after the individual has been awarded an appropriate master's or doctorate degree. Track these hours on the form, "Supervision Plan LMAC Hour Log." If there are anticipated changes in supervision plan, please submit an updated version of this form immediately for pre-approval. (Hours will not count until the plan is approved by NDBACE).

- **A minimum of fifty percent of the supervised practice hours must be supervised by a registered clinical supervisor**
  - **Supervisor must be:**
    - **Licensed Clinical Addiction Counselor or**
    - **Licensed Master Addiction or**
    - **Licensed Addiction Counselor with Registered Supervisor status until December 31, 2023**
- **No more than fifty percent of the clinical training hours may be supervised by other professionals that the supervising addiction counselor deems competent in the area of practice being supervised, and who are either registered as a clinical supervisor by the board that licenses the other professional or determined by the board to be competent to serve as the supervisor.**
- **Supervision of the clinical training hours must consist of a minimum of one hour weekly, face-to-face supervision and may be provided by an off-site supervisor.**

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE ALL INFORMATION

Name:			
Address:	City:	State:	Zip:
Phone:	Email:		
NORTH DAKOTA LICENSE INFORMATION • ND License Number: _____ • Dates of original certification/licensure: _____ • Name of Clinical Supervisor (must meet the requirements outlined above): _____			
Start Date of Supervision:	Anticipated End Date of Supervision:		
Additional Supervisors (must meet requirements above):			
Provide anticipated schedule of Supervision:			

LAC signature _____ Date: _____

Clinical Supervisor signature Date:

DO NOT WRITE BELOW THIS LINE

The above plan for supervision ☐ has ☐has not been approved by the NDBACE. Comments:

Date: _____ Board Reviewer: _____