

Partners in Recovery – Group Clinical Supervision Sign-In Sheet

Topic:	Location:	Hrs:	Date:
Group Facilitator:	Signature and Credentials:		Time:

Facilitator, Please Circle one of the Following for Competency Determination: Interview, Observation, Test

	Last Name	First Name	Title	Status (FT/PT/TEMP)	Agency or Site	Signature	Credentials <small>*Please Print Legibly</small>	Compe Test %
1								
2								
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20								
21								
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39								
40								
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58								
59								
60								

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Agency , Y or N