



Licensed Behavioral Practitioners  
 Licensed Marital and Family Therapists  
 Licensed Professional Counselors

**State Board of Behavioral Health Licensure**

3815 N. Santa Fe, Ste. 110  
 Oklahoma City, OK 73118  
 Telephone: (405) 522-3696  
 Fax: (405) 522-3691  
 www.ok.gov/behavioralhealth

**TERMINATION OF SUPERVISION AGREEMENT**

Please check appropriate license:                     **LPC**                     **LMFT**                     **LBP**

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LPC Regulations, Subchapter 9 of the LMFT Regulations or Subchapter 13 of the LBP Regulations. I understand that a violation of these requirements may result in a loss of supervision hours and/or disciplinary action against both the candidate and the supervisor.

Name of Candidate: \_\_\_\_\_

Candidate's Current Place of Employment: \_\_\_\_\_

Address of Current Place of Employment: \_\_\_\_\_

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

Candidate's Phone #: \_\_\_\_\_ Candidate's Email Address: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

Supervisor's Current Place of Employment: \_\_\_\_\_

Supervisor's Phone #: \_\_\_\_\_ Supervisor's Email Address: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Effective Date of Termination of Supervision Agreement: \_\_\_\_\_

..... **(For office use only)**.....

Date Approved: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Comments: \_\_\_\_\_

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