Ottawa Couple and Family Institute Inc.

Consent for Supervision

I/ We _____

understand that the services that we will be receiving are under the Clinical Supervision of_____ .This means that our therapist will discuss aspects of our care with _____and she/he will be involved in planning our treatment and assessing our progress on a regular basis. This also means that should I/we or the supervisor request it, we may speak or meet in person.

I give my consent to Clinical Supervision.

Signed _____Date____ _____

Printed name_____

Signed _____ Date_____

Printed name _____

Therapist_____Date_____

Supervisor_____Date_____