Suggested format for the

**SUPERVISOR ANNUAL REVIEW**

**OF A NLPtCA ACCREDITED SUPERVISOR**

|  |  |
| --- | --- |
| Name of practitioner: |  |
| Period covered by this review:  |  |

*Use the headings below to review your records and development for the last re-accreditation period. Please refer to the Supervision Policy and Guidelines and the CPD Policy documents for details of requirements. The document should be retained for 5 years.*

## Details of continuing professional development undertaken during the above 12-month period:

*Supervisors must undertake a minimum of 5 hours of CPD which is directly relevant to their practice as a supervisor.*

|  |  |  |  |
| --- | --- | --- | --- |
| Date | CPD activity | How this CPD informs your supervision practice | No of hours |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | Total CPD hours |  |

## Details of all supervision of supervision received during the above 12-month period:

|  |  |  |  |
| --- | --- | --- | --- |
| Type(s) of supervision | Names of supervisor(s) | Dates | Hours of supervision received |
|  |  |  |  |
|  |  |  |  |

## Details of supervision delivered during the above 12-month period:

|  |  |
| --- | --- |
| Hours of supervision delivered |  |
| Ratio of supervision delivered to supervision received |  |

## Self-reflection on supervision practice during the above 12-month period:

|  |
| --- |
|  |

## Confirmation of insurance

*Please present your insurance certificate to your supervisor as evidence of insurance to practice supervision.*

|  |  |
| --- | --- |
| Verification of a valid certificate of Public Liability and Malpractice Insurance or an equivalent letter from an employer. | Tick to confirm |

## Signed and dated:

*Signing this review is confirmation that the criteria for Supervisor Status Annual Renewal have been met.*

**Practitioner Signature : ……………………………………………………………… Date: ………………………………….**

**Supervisor Name: ……………………………………………………………………...**

**Supervisor Signature: ………………………………………………………………… Date: ………………………………….**