Kentucky Coalition
Against Domestic Violence
KCADV

Clinical Supervision Agreement

I am an autonomous Batterer Intervention Provider and I agree to provide one hour per week of clinical supervision to _____.

This supervision will include case discussion, review of reading assignments, skill building, direct observation, or review of audio or video recording of assessment or intervention performed by the associate Batterer Intervention Provider.

This supervision will continue until such time that the provider listed above achieves autonomous functioning, no longer works with batterers, or we agree for supervision to end.

After the associate provider completes two years (4000 hours) of batterer intervention experience, I may recommend to the Coalition Against Domestic Violence that the they be granted autonomous function.

Signature of Supervisor: _____

Printed Name of Supervisor: _____

Date Signed: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Email Address: _____

Signature of Applicant: _____

Printed Name of Supervisor: _____

***Make copies of this form and submit separately if multiple supervisors**