

**Texas Department of State Health Services  
Professional Licensing and Certification Unit  
Licensed Chemical Dependency Counselor Intern  
Direct Observation Documentation Form**

**Name:** \_\_\_\_\_ **Date of Observation:** \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Clinical Evaluation <ul style="list-style-type: none"><li>• Screening</li><li>• Assessment</li></ul> | <input type="checkbox"/> Counseling <ul style="list-style-type: none"><li>• Individual</li><li>• Group</li><li>• Family</li></ul> |
| <input type="checkbox"/> Treatment Planning   |   |
| <input type="checkbox"/> Referral   | <input type="checkbox"/> Education  |
| <input type="checkbox"/> Service Coordination   |   |

**Brief observations of the session:**

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**Intern strengths:**

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**Areas to improve:**

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CI signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
QCC signature

\_\_\_\_\_  
Date