FOR MHP LICENSURE
POST-MASTER’s SUPERVISED EXPERIENCE VERIFICATION

Supervisors must complete this Attachment. Each supervisor MUST sign and date this form to attest to the experience earned. These hours MUST be earned after receipt of an approved masters’ degree.

WHITE OUT IS NOT ACCEPTABLE:
Changes to information entered onto this form are not acceptable unless the supervisor initials the changed information.

PART I - SUPERVISOR INFORMATION:

Name of Supervisor: ___________________________________________ License #: ________________________________

Name of Applicant: ___________________________________________

Supervisor place a checkmark in the box by the license(s) you hold:

□ licensed mental health practitioner (LMHP)

□ licensed independent mental health practitioner (LIMHP)

□ licensed psychologist

□ qualified physician

PART II - MENTAL HEALTH PRACTICE EXPERIENCE:

MHP Activities include: treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, couples, families, or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations.

SUPERVISORS: List only hours that you personally supervised the applicant providing mental health services

NOTE: direct and non-direct hours are reported separately:

1. __________ Number of direct (face-to-face) client contact (clock) hours (when reporting partial hours, use .25 increments)

2. __________ Number of non-direct clock hours

3. __________ Total number of clock hours of mental health activities performed under my supervision.

4. List the dates the above hours of supervised mental health practice was completed (provide FULL dates):

   from __________________ through __________________
   (month/day/year) (month/day/year)

Supervisor’s Signature and Attestation

I state that I am the person completing this form and the statements on this form are true and complete

AND

I have met with the applicant face-to-face for at least 1 hour per week, for hours reported above.

(Date Signed: _____________________________)

(Print/type) SUPERVISOR Name and Title

Signature

(AGENCY/INSTITUTION)

STREET ADDRESS

CITY STATE ZIP