**FOR MARRIAGE AND FAMILY THERAPY**

**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.

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**PART I**

| Name of Supervisor: ___________________________________________ | License #: ________________________________ |
| Name of Applicant: ___________________________________________ |
| Supervisor place a checkmark in the box by the license(s) you hold: |
| □ Licensed Mental Health Practitioner |
| □ Psychologist |
| □ Marriage and Family Therapist who has practiced for 5 years and has completed a five-hour supervision course that may be provided by an association which establishes standards for marriage and family therapy in conformity with accepted industry standards. |

**SUPERVISORS:** List only the hours that you personally supervised the applicant - **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 marriage and family therapy performed under my supervision.
4. List the dates the above hours of supervised marriage and family therapy **was completed** (provide **FULL dates**) under supervision within 5-years of this application. Dates from __________________________ through __________________________ (month/day/year) (month/day/year)

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**Supervisor’s Signature**

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 or 2 hours every 2-weeks, for the hours reported above AND had at least 100 hours supervisor-supervisee contact hours.

(Date Signed: _____________________________)

(Print/type) **SUPERVISOR Name and Title**

Signature

AGENCY/INSTITUTION

STREET ADDRESS

CITY STATE ZIP