

**MARRIAGE AND FAMILY THERAPIST
EXPERIENCE VERIFICATION**

1800 37A-301 (REV. 3/04)

The supervisor must complete this form. Use a separate form for each person verifying hours of supervised experience for licensure as a marriage and family therapist and for each employment setting. Make certain that the form is complete and correct prior to signing. Any change should be initialed by the supervisor and is subject to verification. Experience verification forms are to be submitted by the applicant with his or her application for licensure.

APPLICANT NAME: _____

SUPERVISOR (Please type or print clearly in ink.)

1. SUPERVISOR NAME: Last First Middle

2. ADDRESS: Number and Street

City State Zip Code

3. BUSINESS TELEPHONE:

4. NAME OF APPLICANT'S EMPLOYER:

5. ADDRESS: Number and Street

City State Zip Code

6. BUSINESS TELEPHONE:

7. Experience was gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes No 8. Experience was gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice for the profession? Yes No 9. As the supervisor I provided supervision on a voluntary basis? Yes No
If yes, attach the original written agreement between you and the applicant's employer required by Title 16, California Code of Regulations Section 1833(b)(4).10. Dates the experience is being claimed: From _____ To _____
Mo Day Yr Mo Day Yr

11. How many weeks of supervised experience are being claimed? _____

12. Show only those hours of experience as verified on the weekly summary of hours form. Logged Hours

a. Individual counseling (No Min. or Max. hrs. Required) a. _____

b. Couples, families, and children (Min. 500 hrs.) b. _____

c. Group counseling (Max. 500 hrs.) c. _____

d. Telephone counseling (Max. 250 hrs.) d. _____

e. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes (Max. 250 hrs.) e. _____

f. Workshops, seminars, training sessions, or conferences directly related to marriage, family, and child counseling (Max. 250 hrs.) f. _____

Total _____

13. Face-to-face supervision: Hours per week Logged Hours

a. Individual _____

b. Group (Group supervision contained no more than 8 persons.) _____

14. SUPERVISOR: _____
Type of License License Number State of License Date Originally LicensedIf M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes No

Date Board Certified: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date

Signature