

MARRIAGE AND FAMILY THERAPIST EXPERIENCE VERIFICATION

37A-301 (REV. 1/11)

ÓUÆÜÖÄUØÁÓØPÆXUÜCEŠÁUÖQØPÖÖÙÁ
FÍGÍÁPÜVPÁTÆÜSÓVÁÓŠXÖÉÄÜWQVÖÁUG€€ÄÜCEÖÜCE TÒP VUÉÁÖCEÁJ Í Ì H I Á
VÒŠÓÚPUPÖKÁÇJFÍDÁÍÍEÍÌHEÁÁVTYKÁÇ800DÁHG6E2297Á
ÁYÖÖÁÜQVÖÁCEÖÖÜÖÜKÁ@cc] KØØ , , , Èà•È&æÈ\* [ç

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. Complete a separate form for pre-degree and post-degree hours. Ocmg"egtckp" vjcv"vjg"htq o "ku"eqo rmgvg"cpf"eqttgev"rtkqt"vq"ukipki" Cp{e}jcpig"ujqwnf"dg"pkvkngf"d{vjg"uwrgt"xtuqt"cpf"ku"uwdlgev"vq"sgtkhkecvkqp0 Experience verification forms are to be submitted by the applicant with his or her application for examination eligibility.

FOR HOURS GAINED BEFORE JANUARY 1, 2010

APPLICANT NAME: \_\_\_\_\_

SUPERVISOR (Rngcug"v{rg"qt"rtkp"engctn{kp"kpml)

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. a. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes No b. Was this experience gained in a private practice setting? 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. Dates the experience is being claimed: From To Mo Day Yr Mo Day Yr

10. How many weeks of supervised experience are being claimed? \_\_\_\_\_

11. 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. Telemedicine (Max. 125 hrs.) e. \_\_\_\_\_
f. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes (Max. 250 hrs.) f. \_\_\_\_\_
g. Workshops, seminars, training sessions, or conferences directly related to marriage, family, and child counseling (Max. 250 hrs.) g. \_\_\_\_\_
Total \_\_\_\_\_

12. Face-to-face supervision: Hours per week Logged Hours
a. Individual \_\_\_\_\_
b. Group (Group supervision contained no more than 8 persons.) \_\_\_\_\_

13. SUPERVISOR: Type of License License Number State of License Date Originally Licensed

If 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: \_\_\_\_\_

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Date Signature