VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. ON YOUR LETTERHEAD STATIONERY DESCRIBE THE POST-MASTERS SUPERVISED CLINICAL EXPERIENCE, INCLUDING ALL LOCATIONS. **TYPE OR PRINT LEGIBLY.**

TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

APPLICANT'S NAME: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S LICENSE NUMBER: _____

SUPERVISOR'S ADDRESS: _____

THE SUPERVISOR MUST HAVE:

1. Been in clinical practice as a marital and family therapist at least five (5) years;
2. At least two (2) years experience supervising marital and family therapists;
3. Received at least 36 clock hours of supervision (by an approved supervisor) of his supervisory work by at least two (2) persons doing marital and family therapy; or
4. Completed training for supervision with an AAMFT approved supervisor.
5. **Please submit proof of qualifications.**

THE ABOVE APPLICANT HAS SUCCESSFULLY COMPLETED SUPERVISED CLINICAL TRAINING DURING THE PERIOD _____, _____ TO _____, _____, AS FOLLOWS:

1. Total hours of **CLINICAL CONTACT IN MARRIAGE AND FAMILY THERAPY** provided by the applicant during the time you supervised him/her.

   _____ hours

2. Total hours of **INDIVIDUAL SUPERVISION** of this work (200 are required).

   _____ hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND THAT I MEET THE ABOVE SUPERVISOR QUALIFICATIONS.

_____ _____

SUPERVISOR'S SIGNATURE DATE

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

_____

NOTARY PUBLIC

MY COMMISSION EXPIRES _____ AFFIX SEAL HERE

SEND TO: Board for PC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

THIS PAGE MAY BE DUPLICATED IF NEEDED.