



APPLICATION FOR LICENSURE AS A ASSOCIATE MARRIAGE & FAMILY THERAPIST

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive, Macon, Georgia 31217

Phone (404) 424-9966

[Board of Professional Counselors, Social Workers, and Marriage & Family Therapists | Georgia Secretary of State \(ga.gov\)](#)

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Marriage & Family Therapy in the State of Georgia. Visit the Board's web site for information.

****Important****

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are withdrawn after sixty (60) days.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a **COMPLETE** application.

PLEASE ACCESS THE BOARD RULES WHICH INCLUDES LICENSURE REQUIREMENTS FROM OUR WEBSITE AT
[Board of Professional Counselors, Social Workers, and Marriage & Family Therapists | Georgia Secretary of State \(ga.gov\)](#)

- NOTARIZED APPLICATION:** THE APPLICATION MUST BE MAILED TO THE BOARD'S OFFICE AT THE ADDRESS LISTED ABOVE, ALONG WITH YOUR **FEE**. ALL QUESTIONS MUST BE ANSWERED. ANY QUESTION ANSWERED "YES", REQUIRES FURTHER DOCUMENTATION TO BE SUBMITTED. REQUEST OFFICIAL COURT DOCUMENTS BE SUBMITTED TO THE BOARD AND PROVIDE AN EXPLANATION IF YOU HAVE HAD ANY CRIMINAL CONVICTIONS OR CHARGES, OR SANCTIONS BY ANOTHER STATE LICENSING BOARD. THE BOARD, AT THEIR NEXT SCHEDULED MEETING, WILL REVIEW THE APPLICATION WITH REQUIRED DOCUMENTATION. APPROVAL OF LICENSURE IS AT THE BOARD'S DISCRETION.
- NATIONAL BOARD SCORES:** IF YOU HAVE NOT TAKEN THE MFT EXAM, YOU WILL RECEIVE THE EXAM PACKET INFORMATION AFTER BOARD APPROVAL. ALL APPLICANTS ARE REQUIRED TO PASS THE MARRIAGE & FAMILY THERAPY EXAMINATION. IF YOU HAVE TAKEN THE MFT EXAM, PLEASE CONTACT THE EXAM VENDOR AND HAVE THEM CERTIFY YOUR SCORES TO GEORGIA.
- DEGREE TRANSCRIPT:** ALL APPLICANTS FOR LICENSURE MUST HAVE EARNED A MASTER'S DEGREE IN MARRIAGE & FAMILY THERAPY, COUNSELING, SOCIAL WORK, MEDICINE, APPLIED PSYCHOLOGY, PSYCHIATRIC NURSING, PASTORAL COUNSELING, APPLIED CHILD AND FAMILY DEVELOPMENT, APPLIED SOCIOLOGY, OR FROM ANY PROGRAM ACCREDITED BY THE COMMISSION ON ACCREDITATION FOR MARRIAGE AND FAMILY THERAPY EDUCATION. SUCH DEGREE SHALL BE FROM AN EDUCATIONAL INSTITUTION ACCREDITED BY A REGIONAL BODY RECOGNIZED BY THE COUNCIL ON POST SECONDARY ACCREDITATION. AN **OFFICIAL** COLLEGE TRANSCRIPT CERTIFYING THE GRADES, DEGREE CONFERRED AND THE DATE AWARDED MUST BE RECEIVED IN THIS OFFICE DIRECTLY FROM THE REGISTRAR OF THE COLLEGE/SCHOOL.
- NAME CHANGE:** IF YOUR NAME HAS CHANGED SINCE YOU ATTENDED SCHOOL, PLEASE MAKE A NOTE ON THE APPLICATION ADVISING OF YOUR FORMER NAME(S) SO WE CAN MATCH-UP THE DOCUMENTS WITH YOUR APPLICATION.

- FORM A/INTERNSHIP VERIFICATION:** THE INSTRUCTOR OF RECORD AT THE COLLEGE OR UNIVERSITY OR THE SITE SUPERVISOR MAY BE VERIFIED BY THE SCHOOL AS PART OF THE MASTER'S DEGREE PROGRAM WHICH INCLUDES A GRADUATE LEVEL COURSE OVER 12 CONSECUTIVE MONTHS, UNDER SUPERVISION, MINIMUM OF 500 HOURS MFT CLINICAL CONTACT.
- FORM B/PRACTICUM/INTERNSHIP VERIFICATION:** PRACTICUM/INTERNSHIP MUST MEET MINIMUM REQUIREMENTS SET OUT IN BOARD RULE 135-5-.06. COMPLETE A SEPARATE FORM FOR EACH PRACTICUM/INTERNSHIP LISTED ON YOUR APPLICATION.
- CONTRACT AFFIDAVIT:** YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY. THE PURPOSE OF THE CONTRACT AFFIDAVIT IS TO DEFINE THE EMPLOYMENT RELATIONSHIP FOR THE PURPOSE OF ACQUIRING THE REQUIRED POSTMASTER'S EXPERIENCE UNDER SUPERVISION THAT WILL BE APPLICABLE FOR LICENSURE. INDEPENDENT PRIVATE PRACTICE IS NOT ACCEPTABLE AS "EMPLOYMENT" FOR THE PURPOSES OF OBTAINING DIRECTED EXPERIENCE UNDER SUPERVISION.
- OTHER STATE LICENSURE CERTIFICATION:** IF YOU ARE OR HAVE EVER BEEN LICENSED IN ANOTHER STATE(S), PLEASE HAVE THAT/THOSE STATE(S) OFFICIALLY CERTIFY THAT LICENSE DIRECTLY TO THE BOARD'S OFFICE.
- REFERENCES:** PLEASE SUBMIT REFERENCES FROM TWO (2) TEACHERS OR SUPERVISORS WHO ARE FAMILIAR WITH THEIR EXPERIENCE IN MARRIAGE & FAMILY THERAPY.
- CONSENT FORM:** PLEASE SIGN THE CONSENT FORM GIVING PERMISSION FOR THE BOARD TO RECEIVE ANY CRIMINAL HISTORY RECORD INFORMATION.
- IMPORTANT:** APPLICANTS, PLEASE NOTE WHEN ACCESSING YOUR APPLICATION STATUS ON OUR WEBSITE THROUGH THE LINK "CHECK THE STATUS OF AN APPLICATION", THAT CHECKLIST ITEMS MOVED OVER TO THE COMPLETED COLUMN ONLY MEANS THAT THOSE DOCUMENTS HAVE BEEN RECEIVED. PLEASE ALLOW SEVERAL DAYS FROM THE SUBMISSION OF ANY FORMS, DOCUMENTS ETC TO BE PROCESSED BEFORE ACCESSING THE WEB LINK FOR A STATUS UPDATE.
- ONLY THE GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPIST HAS THE AUTHORITY TO APPROVE OR DENY AN APPLICATION FOR LICENSURE. EVERY APPLICATION FILE MUST BE PRESENTED TO THE BOARD FOR REVIEW.

PART II - PROFESSIONAL BACKGROUND

ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION AND PRINT AND **COMPLETE THE "CONSENT FORM FOR BACKGROUND CHECK" AND SUBMIT WITH YOUR APPLICATION** (Available on the same webpage as this application was).

- Yes No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?
- Yes No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
- Yes No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?
- Yes No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- Yes No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- Yes No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- Yes No 7. Have you ever been convicted of any criminal offense?
- Yes No 8. Have you ever been arrested, charged, or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the "Georgia First Offenders Act"? You must respond "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.
- Yes No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- Yes No 10. Do you now hold or have you ever held a license as a marriage and family therapist (or an Associate level MFT) in any jurisdiction? If "yes," complete the following:
Jurisdiction _____ License No. _____
Date Issued _____ Expiration _____
- Yes No 11. Have you previously applied to the Board for the same license for which you are currently applying?
If "yes," name under which application was submitted: _____
- Yes No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

PART III — GRADUATE EDUCATION

- For licensure as an Associate Marriage and Family Therapists, you must have satisfied one of three (3) educational requirements. See Board Rule 135-5-.05(b).
- Submit an official certified copy of your transcript, or, direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office: 237 Coliseum Drive, Macon, GA 31217-3858.

THREE (3) COURSES IN HUMAN DEVELOPMENT

“Human development courses” encompass the study of all aspects of individual development across the life span. Such courses include, but are not limited to, theories of individual development, theories of learning, theories of personality development, theories of normal and abnormal behavior, human sexuality, and psychopathology. Board Rule 135-5-.05(a)(8).

1.	
2.	
3.	

ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS

A course in “Marriage and Family Ethics” includes, but is not limited to: state and federal laws, Rules of the Georgia Composite Board of PC, SW & MFT, professional ethics, legal responsibilities and liabilities, professional socialization, professional organization, interprofessional cooperation, licensure legislation and independent practice. Board Rule 135-5-.05(a)(9).

1.	
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ONE (1) COURSE IN RESEARCH

A course in “Research” includes, but is not limited to, research design, methods, and statistics, but not credit received for thesis or dissertation. Board Rule 135-5-.05(a)(10).

1.	
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A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY

1.	
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Date Began:	Date Ended:	Total # Hours Clinical Experience:	Total # Hours of Supervision:
NAME OF SUPERVISOR:		MFT License #	State:

Board-Approved Supervisor AAMFT-Approved Supervisor Not an Approved Supervisor

PART IV - POST-MASTER'S DIRECTED EXPERIENCE UNDER SUPERVISION

INSTRUCTIONS:

■ An applicant for licensure as an Associate Marriage and Family Therapist must submit to the Board the Post-Master's Experience under Direction and Supervision Contract Affidavit.

DATE ALL EDUCATIONAL REQUIREMENTS WERE COMPLETED: _____

DATE MFT EXAMINATION TAKEN AND PASSED (IF APPLICABLE): _____

I have completed and am submitting as part of this application the Post-Master's Directed Experience under Supervision Contract Affidavit.

I acknowledge that if I change work settings, contract terms, or supervisors, I must request and receive approval from the Board by completing a new Contract and submitting it to the Board for approval.

AFFIDAVIT REGARDING CITIZENSHIP

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY. Submit this document along with a copy of your secure and verifiable document to the Board with your application.

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists, for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

- 1) _____ I am a United States citizen. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver’s license, passport, or other document as indicated on the Boards website.**

- 2) _____ I am **not** a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in _____ (City), _____ (State).

Signature of Applicant

Printed Name of Applicant

Sworn to and subscribed before me this
_____ day of _____ 20____

Notary Public Signature

My Commission Expires: _____

NOTE to NOTARY: Application must be signed with Proper ID.

(Notary Seal)

**MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION
 FORM A**

- Please type or print clearly. For additional forms, please photocopy. This is a 2-page form.
- Practicum/Internship must meet the requirements set out in Board Rule 135-5-.06 [Graduate level course over 12 consecutive months, under supervision, minimum 500 hours MFT clinical contact.]
- **Applicant** – Complete Part I.
- **On-Site Coordinator of Practicum/Internship** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name:

Address:

Street

City

State

Zip

√ Check applicable and complete information below:

- Practicum/Internship which was **part of my degree program** OR
- Practicum/Internship **before or after the master's degree.**

√ Check Type of Practicum/Internship: MFT PC SW

Institution:

Degree:

Course Title & Number:

Supervisor:

Practicum/Internship Site:

Address:

Position/Title:

Description of Responsibilities:

DATES:

FROM:

Month/Year

TO:

Month/Year

DURATION:

TOTAL YEARS:

TOTAL MONTHS:

HOURS OF ON-SITE EXPERIENCE

Individuals:

Group:

Couples/Families:

OATH

I attest that the above information is a true and accurate representation of my Practicum/Internship.

_____ Date

_____ Signature of Applicant

Subscribed to and sworn before me _____

Printed Name

This ____ day of _____, _____

 Notary Public

My Commission Expires: _____

NOTARY SEAL

FORM A-PART II - TO BE COMPLETED BY THE ON-SITE COORDINATOR

INSTRUCTIONS:

- Please review the applicant's description of his/her Practicum/Internship experience. If you have any additional information that would assist the Board in making a decision on licensure for this applicant, please provide that information below.
- Complete A or B below, as applicable.

ADDITIONAL INFORMATION:

A - ACTUAL ON-SITE COORDINATOR

ATTESTATION:

I attest that I served as the On-Site Coordinator for the Practicum/Internship described above and that this description is a true and accurate representation of this applicant's experience.

Date

Signature of On-Site Coordinator

Printed Name

Name of Site:

Address: _____
Street City State Zip

Work Phone: () Home Phone: () Fax: ()

B - CURRENT ON-SITE COORDINATOR

ATTESTATION:

I attest that the person who coordinated this applicant's Practicum/Internship cannot be located and that I am the current On-Site Coordinator and can verify this applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the Practicum/Internship described above is a true and accurate representation of this applicant's experience.

Date

Signature of Current On-Site Coordinator

Printed Name

Name of Site:

Address: _____
Street City State Zip

Work Phone: () Home Phone: () Fax: ()

**MARRIAGE AND FAMILY THERAPY VERIFICATION OF PRACTICUM/INTERNSHIP SUPERVISION
 FORM B**

- Please type or print clearly.
- Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I. For additional forms, please photocopy. Complete a separate form for each Practicum/Internship listed on you're application.
- **Practicum/Internship Supervisor** - Complete Part II. After you have completed this form and it has been notarized, enclose it in a sealed envelope, sign your name over the flap and return it to the applicant.

PART I - TO BE COMPLETED BY APPLICANT

PRINT Name: _____ Social Security #: _____/_____/_____

PART II - TO BE COMPLETED BY THE PRACTICUM/INTERNSHIP SUPERVISOR

Name of Supervisor:

Type of License: MFT LPC CSW PSYCHOLOGIST PSYCHIATRIST

License # _____ State: _____ Date Issued: _____ Expiration Date: _____

CERTIFICATION:

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced:
 Marriage and Family Therapy Professional Counseling Social Work

Practicum/Internship Site:

Address: _____ Street _____ City _____ State _____ Zip _____

FROM: _____ Month/Year	TO: _____ Month/Year	TOTAL MONTHS: _____
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SUPERVISION: This applicant received the following supervision from me:

INDIVIDUAL: _____ Hours/Week GROUP: _____ Hours/Week

Total Number of Hours: _____

- I certify that at the time of the documented supervision I met one of the following criteria:
 AAMFT Approved Supervisor AAMFT Supervisor In Training GA Board LMFT Approved Supervisor
- DESCRIPTION OF PRACTICE SUPERVISED (Use a separate page if needed):**

OATH

I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.

 Signature of Internship/Practicum Supervisor Date _____ (Please Print Name Clearly-Supervisor)

Subscribed to and sworn before me
 this ____ day of _____, 20____

 Notary Public
 My Commission Expires: _____

NOTARY SEAL

MARRIAGE AND FAMILY THERAPIST
PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM C

APPLICANTS:

- Make every effort to locate the supervisor(s)/instructor(s) of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor(s), you may attest to undocumented supervision of practicum/internship by taking the Oath below.
- The Board may require additional information upon review.

OATH

Under penalty of perjury as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate the supervisor below.

Name of Supervisor: _____

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy

during the period of : _____ to _____ For _____ Total Number of Hours
Month/Year Month/Year

and during that period he/she was licensed as a:

- Marriage and Family Therapist
- Professional Counselor
- Clinical Social Worker
- Psychologist
- Psychiatrist

License Number: _____ In the State of: _____

During that period he/she was: AAMFT Approved Supervisor or Supervisor in Training
 Georgia Board Approved Supervisor

I have attached copies of letters and/or returned mail that demonstrate my attempt(s) to reach this supervisor.

Printed Name of Applicant

Signature of Applicant

Sworn to and subscribed before me this

Date

_____ day of _____, 20____.

Notary Public

My Commission Expires:

Notary Seal

APPLICATION FOR ASSOCIATE MARRIAGE AND FAMILY THERAPIST PERSONAL REFERENCE
FORM
FORM D

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Marriage and Family Therapy.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, if not picked up by applicant, return it to the applicant. Applicant will submit with application. If you choose to submit the form directly to the Board, please either fax to 866-888-7127, or mail to 237 Coliseum Drive, Macon, GA 31217
The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name: _____

PART II - REFERENCE

Name: _____

Address: _____

Day Phone: () ()

Other Phone: () ()

Relationship to Applicant: Teacher Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:

Title: _____

Agency/Institution: _____

Address: _____

RECOMMENDATION: I Recommend Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date

Signature of Reference

POST-MASTER'S EXPERIENCE UNDER DIRECTION AND SUPERVISION
CONTRACT AFFIDAVIT

INSTRUCTIONS:

NO FAXED FORMS ACCEPTED

- The purpose of this Contract Affidavit is to define the employment relationship for the purpose of acquiring the required post-master's experience under the direction and supervision that will be applicable for licensure pursuant to O.C.G.A. § 43-10A et. seq.
- For the specific definitions of terms pertaining to specific licenses, see the Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135-5).
- In addition to the above, all contractual parties are required to adhere to all local, state, and federal laws and regulations pertaining to all aspects of this contractual agreement whether written or implied. This includes, but is not limited to, the payment of local, state and federal taxes, minimum wage guidelines, assessment and collection of fees, insurance reimbursement claims, etc.
- Independent private practice or practice under O.C.G.A. § 43-10A-7, sections (9), (10), (13), (14), (15), (16) or (17) is **not** acceptable as "employment" for the purposes of obtaining directed experience under supervision.
- **NOTE: You must complete a separate Contract Affidavit for each directed experience site and /or supervisor.**
- **YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY.**

PART I — APPLICANT

***** TO BE COMPLETED BY THE APPLICANT *****

NAME:

Last

First

Other[Middle/Maiden]

ADDRESS:

Street

City

State

Zip

HOME TELEPHONE: ()

OFFICE TELEPHONE: ()

SOCIAL SECURITY NUMBER:

[Optional: For Identification, Law Enforcement, Statistical and Administrative Purposes]

LICENSE APPLIED FOR: LAPC LPC LMSW LCSW LAMFT LMFT

EDUCATION

DEGREE EARNED: Master's Master's Specialist Doctorate: Ph.D. Ed.D.

(Transcript MUST indicate on the transcript the type of degree earned checked above)

PRACTICUM/INTERNSHIP

Did you complete a Practicum/Internship as part of your degree program? Yes No

If "Yes," Name of Site: _____

Start Date: _____ End Date: _____

Name of Practicum/Internship Supervisor who was Instructor of Record for the course: _____

LICENSED AS: LPC LCSW LMFT Psychologist Psychiatrist

At the time of your practicum was your supervisor one of the following?

AAMFT Approved Supervisor or Supervisor in Training GA Board Approved Supervisor

VERIFICATION

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice or practice under O.C.G.A. § 43-10A-7 (9), (10), (11), (14), (15), (16) or (17) while obtaining the required experience for licensure.

Date

Signature of Applicant

PART II - DIRECTED EXPERIENCE
***** TO BE COMPLETED BY THE DIRECTOR *****

- The purpose of DIRECTION is to provide ongoing administrative oversight by an employer or superior in the practitioner's area of specialty.
- The Director is responsible for assuring the quality of the services provided and ensuring that qualified clinical supervision or intervention occurs in situations that require expertise beyond that of the employee.
- The Director must be located on-site and is specifically responsible for ensuring regularly-scheduled reviews of employee compliance with the Rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135) and all relevant federal, state, and local laws and regulations.
- **NOTE: Director and applicant (employee) must describe the content of the training experience and complete Part IV, Plan for Direction Section, on page 4.**

DIRECTOR

NAME: _____

TITLE/POSITION: _____

IF APPLICABLE: LPC LCSW LMFT Psychologist Psychiatrist
 Date License Issued: _____ Expires: _____ State: _____ Highest Earned Degree: _____

HOME TELEPHONE: () _____

OFFICE TELEPHONE: () _____

EMPLOYMENT SITE

NAME OF EMPLOYMENT SITE: _____

ADDRESS: _____

Street City State Zip

OTHER PROFESSIONAL STAFF AT EMPLOYMENT SITE (ATTACH A SEPARATE SHEET, IF NECESSARY):

1.	_____	_____	_____	_____
	<i>Name</i>	<i>Degree</i>	<i>License (If Applicable)</i>	<i>Job Title</i>
2.	_____	_____	_____	_____
	<i>Name</i>	<i>Degree</i>	<i>License (If Applicable)</i>	<i>Job Title</i>
3.	_____	_____	_____	_____
	<i>Name</i>	<i>Degree</i>	<i>License (If Applicable)</i>	<i>Job Title</i>
4.	_____	_____	_____	_____
	<i>Name</i>	<i>Degree</i>	<i>License (If Applicable)</i>	<i>Job Title</i>
5.	_____	_____	_____	_____
	<i>Name</i>	<i>Degree</i>	<i>License (If Applicable)</i>	<i>Job Title</i>

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A and the Rules of the Board and I agree to comply completely with all laws of the State of Georgia and Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that this individual may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice, or practice under O.C.G.A. § 43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made, and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

Signature of Applicant (Employee) _____ Printed Name _____ Date _____

Signature of Director _____ Printed Name _____ Date _____

Subscribed and sworn before me this _____
 day of _____, 20_____

My Commission Expires: _____

NOTARY SEAL

PART IV — TRAINING EXPERIENCE AND PLAN FOR DIRECTION

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe in detail below the content of the training experience and the specific plan for “Direction.”
- The plan must include, but is not limited to: 1) A description of the nature of the services being provided to the public; 2) **the wages, salaries or other monetary considerations**; and 3) a description of and declaration that both the direction and supervision occur on a regular basis.

PLAN FOR DIRECTION:

Signature of Director

Date

Signature of Applicant (Employee)

PART V — PLAN FOR SUPERVISION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe the specific “Supervision Plan” for this applicant (supervisee).
- “Supervision” means the direct, i.e., face-to-face, clinical review for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee’s interaction with a client/s. Supervision may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observations.
- **CONTRACT/AFFIDAVIT MUST SPECIFY THE NUMBER OF HOURS PER WEEK TO MEET THE 30 MINIMUM HOURS PER YEAR.**

PLAN FOR SUPERVISION

Signature of Supervisor

Date

Signature of Applicant (Employee)