GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 (Telephone)
www.sos.state.ga.us/plb/counselors

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.

ADDITIONAL COURSEWORK (Attach additional sheets, if necessary)

1._____
Course Title College/University

2._____
Course Title College/University

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 * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- 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. _____
   Name Degree License (If Applicable) Job Title
2. _____
   Name Degree License (If Applicable) Job Title
3. _____
   Name Degree License (If Applicable) Job Title
4. _____
   Name Degree License (If Applicable) Job Title
5. _____
   Name Degree License (If Applicable) Job Title

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 _____, _____.

_____

My Commission Expires:_____ **NOTARY SEAL**

PART III — SUPERVISION

* * * TO BE COMPLETED BY THE SUPERVISOR * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- "SUPERVISION" is the direct clinical review, for the purposes of training or teaching, by a supervisor of interaction with a client/s in order to promote the development of clinical skills. It may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observation.
- The supervisor assumes complete clinical responsibility for all clients.
- The supervisor **does not** have to be located on-site.
- IMPORTANT: The requirements to be eligible to serve as a supervisor differ for Professional Counseling, Social Work and Marriage and Family Therapy. The number of hours and type (individual and/or group) of supervision is also specific to each license. See Chapter 135-5, Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Therapists for the precise requirements.
- NOTE: SUPERVISOR and APPLICANT (Employee) must complete PART V, Plan for Supervision, on page 4.

SUPERVISOR

NAME OF SUPERVISOR:

TITLE/POSITION:
IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist
Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

SUPERVISOR'S EMPLOYMENT SITE:

ADDRESS:
Street City State Zip

Do you have any current or prior relationship with the applicant/employee? ❒ No ❒ Yes If "Yes," please explain:

MFT SUPERVISORS ONLY:

1. Do you intend to supervise this applicant for licensure as a Marriage and Family Therapist or Associate Marriage and Family Therapist? ❒ Yes ❒ No
2. If "Yes," have you obtained one of the following required designations?
   ❒ Board Approved MFT Supervisor ❒AAMFT Approved Supervisor

   Supervisor's Name: _____

☞ See Board Rule 135-5-.06 for specific information.

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand my responsibilities as a supervisor under O.C.G.A. § 43, Chapter 10A and the Rules of the Board and that I will assure complete compliance 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. In addition, I assume full responsibility for all aspects of the clinical services provided by this individual. Furthermore, I have reviewed this Contract Affidavit and will ensure that this individual will not practice without appropriate direction, 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 Supervisor Printed Name Date

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

_____
My Commission Expires: _____ **NOTARY SEAL**

PART IV — TRAINING EXPERIENCE AND PLAN FOR DIRECTION

INSTRUCTIONS:

- 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)

DATE APPROVED BY BOARD:	STANDARDS COMMITTEE: ❒ PC ❒ SW ❒ MFT

Standards Committee Member	Standards Committee Member	Standards Committee Member