



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

APPLICATION FOR PROFESSIONAL COUNSELOR LICENSE
POST-MASTER'S CLINICAL SUPERVISION VERIFICATION FORM
FORM E

APPLICANT

- **Complete Part I** and forward this form to each supervisor from whom you obtained direct, clinical supervision as defined in Board Rule 135-5-.02. Complete a separate form for each Supervisor listed in your application. Use this form to only verify Professional Counseling CLINICAL supervision.
- If you need additional forms, you may photocopy this form.

DIRECTED EXPERIENCE SUPERVISOR

- The Supervisor must Complete Part II and return form to the Applicant for inclusion with the application for licensure OR submit directly to the Board office.
- "Supervision" means the direct clinical review by an eligible Supervisor for the purpose of training or teaching of a Professional Counselor's interaction with a client.
- The dates must be noted on the form. **"Present" or "Current" is not acceptable in lieu of an actual date.**

PART I - APPLICANT

NAME OF APPLICANT: _____
 First Middle Last Maiden

PART II – CLINICAL SUPERVISOR

I HEREBY CERTIFY THAT I PROVIDED DIRECT CLINICAL SUPERVISION OF THE ABOVE-NAMED INDIVIDUAL AS DEFINED IN BOARD RULE 135-5-.02 FOR THE PERIOD INDICATED BELOW

SUPERVISION:

Supervision Provided: *Dates Required	From: (Month/Day/Year)	To: (Month/Day/Year)	Total Number of Hours:
Description of Practice Supervised:			

I attest that I served as this Applicant's Clinical Supervisor, as defined in Board Rule 135-5-.02 and that this description is a true and accurate representation of my clinical supervision of this Applicant.

I Recommend Do Not Recommend this Applicant for licensure.

_____ Date _____ Signature of Clinical Supervisor

Highest Level of Education Completed Master's Master's Specialist EdD PhD Other

Printed Name: _____

Address: _____
 Street City State Zip Code

Telephone #: (____) _____ Fax #: (____) _____

License Type:	License #:	State:	Date Originally Issued:	Current Exp. Date:
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Sworn to and subscribed before me this
 _____ day of _____, _____.

 Notary Public
 My Commission Expires: _____

NOTARY SEAL