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

PROFESSIONAL COUNSELOR
POST-MASTER'S MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM F

INSTRUCTIONS:

- Please type or print clearly.
- Supervision must have been obtained while you engaged in post-master's directed experience. Supervision must meet the standards set out in the Rules for Professional Counselors. **The Clinical Supervisor must be:** Either be licensed as a: Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or a Certified Rehabilitation Counselor based on the criteria specified in Board rule 135-5-.02.
- Meet the post-licensure experience requirements for the degree held. See Board Rule Chapter 135-5-.02

APPLICANT:

- Make every effort to locate the as many of the Supervisors as necessary to document the required supervision.
- If, however, you have obtained sufficient supervision to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented supervision by taking the Oath below.
- You must provide documentation to show your diligence. Examples include: returned mail, copies of letters etc.
- The Board may require additional information upon review.

PART I - APPLICANT

FULL NAME:

OATH

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

Name of Supervisor:_____

who served as my clinical supervisor while I worked under the direction of:

Name of Director: _____

at:_____
Name of Agency or Organization Address City State Zip Code

and that this supervisor has the following credentials:
License Type: ❒ Professional Counselor ❒ Clinical Social Worker ❒ Marriage and Family Therapists
❒ Psychologist ❒ Psychiatrist ❒ Certified Rehabilitation Counselor

License #: _____ State: _____ Date Issued: _____ Expir. Date: _____

SUPERVISION:

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

_____ _____
Date Signature of Applicant

Sworn to and subscribed before me this

_____day of _____, _____.

_____

Notary Public

My Commission Expires: _____ NOTARY SEAL