



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

MARRIAGE AND FAMILY THERAPY
VERIFICATION OF SUPERVISION OF DIRECT POST GRADUATE CLINICAL EXPERIENCE
FORM E

INSTRUCTIONS: NO FAXED FORMS ACCEPTED

- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each Supervisor listed on your Application.
- The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. Seen Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Supervisor of Direct Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____

Address: _____
Street City State Zip

Name of Supervisor: _____

The Supervision was in the practice of: MFT PC SW

DATES OF SUPERVISION:	FROM: _____ Month/Year	TO: _____ Month/Year
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DURATION OF SUPERVISION:	TOTAL YEARS: _____	TOTAL MONTHS: _____
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DESCRIBE THE PRACTICE:

DESCRIBE THE SUPERVISION:

ATTESTATION

I attest that the above information is a true and accurate representation of my practice and supervision.

Date

Signature of Applicant

Printed Name

FORM E - PART II - TO BE COMPLETED BY THE SUPERVISOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "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 client(s). Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observations.
- Please review the Applicant's description of his/her practice and supervision. 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.

Name of Supervisor: _____

Address: _____
Street City State Zip

Type of License: MFT PC CSW PSYCHOLOGIST PSYCHIATRIST

License # State: _____ Date Issued: _____ Expiration Date: _____ Years of Practice: _____

ADDITIONAL INFORMATION:

**SUPERVISION
THIS APPLICANT RECEIVED THE FOLLOWING SUPERVISION FROM ME:**

I supervised the above-named Applicant in the practice of:
 Marriage and Family Therapy Professional Counseling Social Work

DATES OF SUPERVISION:	FROM: _____ Month/Year	TO: _____ Month/Year
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DURATION OF SUPERVISION:	TOTAL MONTHS:	TOTAL YEARS:
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INDIVIDUAL: _____ Hours/Week	GROUP: _____ Hours/Week	TOTAL HOURS:
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I hereby certify that at the time of the documented supervision, I met one of the following criteria:
 AAMFT-Approved Supervisor Term Expires On: _____
 In Supervision of Supervision Date Supervision of Supervision Began: _____
 Georgia Board Approved MFT Supervisor Date Approved: _____

OATH

I attest that I served as this Applicant's supervisor as prescribed by law, and the description of the supervision provided in this Application is a true and accurate representation of my supervision with this Applicant.

I RECOMMEND DO NOT RECOMMEND this Applicant for licensure.

_____ Date _____ Signature of Supervisor

Subscribed to and sworn before me

this ____ day of _____, _____

 Notary Public
 My Commission Expires: _____

NOTARY SEAL