GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
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www.sos.state.ga.us/plb/counselors

MARRIAGE AND FAMILY THERAPIST
POST-MASTER'S DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM F

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- The years and hours of supervision required for MFT licensure depend on the degree you hold.
- **The Directed Experience Supervisor must: Be a licensed:** Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist and Meet the post-licensure experience requirements for the degree held. See Board Rule Chapter 135-5-.06.

APPLICANT:

- Make every effort to locate as many of the directors of Directed Experience as necessary to document the required Directed Experience Supervisor.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience 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.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME: SOCIAL SECURITY NUMBER:

I hold a: **Master's Degree**: ❒ PC ❒ CSW ❒ MFT ❒ Rehabilitation Counseling ❒ Specialist
Allied Degree: ❒ Medicine ❒ Psychiatric Nursing ❒ Psychology ❒ Pastoral Counseling
❒ Child & Family Development ❒ Applied Sociology **Doctorate Degree**: ❒ Ph.D. ❒ Ed.D.

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:

Name of Supervisor:_____

who served as my supervisor while I worked under the direction of: _____
Name of Director

at:_____
Name of Agency or Organization Address City State ZIp

and that this supervisor has the following credentials:

License Type: ❒ Professional Counselor ❒ Clinical Social Worker ❒ Marriage and Family Therapy
❒ Psychologist ❒ Psychiatrist

License #: _____ State:_____ Date Issued:_____ Expir. Date: _____ Years of Practice After Licensed:____

At the time the supervision took place the supervisor was (check one)

❒AAMFT-Approved Supervisor ❒AAMFT- Supervisor in Training ❒Georgia Board Approved Supervisor

DATES OF SUPERVISION:	FROM: **Month/Year**	TO: **Month/Year**	
DURATION OFSUPERVISION:	TOTAL MONTHS:	TOTAL YEARS:	
INDIVIDUAL:_____ Hours/Week	GROUP: _____ Hours/Week	TOTAL HOURS:	

I **have attached copies of letters and/or returned mail that demonstrates my attempts to reach this supervisor.**

_____ _____
Date Signature of Applicant

Sworn to and subscribed before me this
_____day of _____, _____.

_____
Notary Public
My Commission Expires: _____. NOTARY SEAL