GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS

https://sos.ga.gov/licensing-division-georgia-secretary-states-office

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: