GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE AND FAMILY THERAPISTS
https://sos.ga.gov/licensing-division-georgia-secretary-states-office

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

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- Complete a separate form for each experience listed on your Application.
- Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Director of 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

Position/Title:

Description of Responsibilities:

The Clinical Experience was in the practice of: ❒ MFT ❒ PC ❒ SW

DATES OF EXPERIENCE:	FROM: _____ Month/Year	TO: _____ Month/Year
DURATION OF EXPERIENCE:	TOTAL YEARS:	TOTAL MONTHS:

HOURS OF CLINICAL EXPERIENCE IN A TYPICAL WEEK
[Do not indicate a range of hours — e.g., 5 to 10]

CLINICAL ACTIVITY (Weekly)	**(TYPE OF CLIENT) Individual**	**Couple/Family**
A) Client contact as therapist or co-therapist	# of Hours:	# of Hours:
B) Case staffing or Case Consultation	# of Hours:	# of Hours:
C) Clinical Supervision (As a supervisee)	# of Hours:	# of Hours:

ATTESTATION

I attest that the above information is a true and accurate representation of my Direct Clinical Experience.

_____ _____
Date Signature of Applicant

_____
Printed Name

FORM D-PART II - TO BE COMPLETED BY THE DIRECTOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "Direction" means the ongoing administrative oversight by an employer or superior of a special practitioner's work. Direction may be provided by any person acceptable to the standards committee for that specialty in which the practitioner is working. The Director shall be responsible for assuring the quality of the services rendered by the practitioner and shall ensure that qualified supervision or intervention occurs in situations which require expertise beyond that of the practitioner.
- An "Employer" is a person who employs the services of others; one for whom employees work, who has the right to control and direct the person who performs services, and who pays their wagers or salaries or other monetary consideration for their services.
- Please review the Applicant's description of his/her Directed Clinical Experience. If you have any additional information which would assist the Board in making a decision on licensure for this Applicant, please provide that information below.
- Complete A or B below, as applicable and **sign before a Notary Public**.

ADDITIONAL INFORMATION:

A - ACTUAL DIRECTOR

OATH:

I attest that I provided the direction, as prescribed by law, of the Direct Clinical Experience described on this Application and that this description is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of Director

_____

Printed Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

B - CURRENT DIRECTOR

OATH:

I attest that the person who provided this Applicant's direction cannot be located, that I am the current Director and can verify this Applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the description above of this experience is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of Current Director

_____

Printer Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )