SUPERVISED EXPERIENCE ATTESTATION FORM

Print clearly or type the following information:

Applicant's Name _____ Intern Registration No._____

☐ **Clinical Social Work** ☐ **Marriage & Family Therapy** ☐ **Mental Health Counseling**

Supervisor's General Information (to be completed by supervisor)

Supervisor's Name:		Phone:	
Address:			
License/Certification Title	**State**	**Original Licensure Date**	**License Number**
Other Professional Credential	**Organization**	**Original Certificate Date**	**Certification Number**

Supervised Experience Affirmation (to be completed by supervisor)

I have read and understand Rule Chapter 64B4-2, F.A.C. I provided at least one (1) hour of supervision per fifteen (15) hours of psychotherapy face-to-face with clients provided by the intern, with a minimum of one (1) hour of supervision every two (2) weeks. Supervision was provided from

_____/_____/_____ to _____/_____/_____ for a total of _____ weeks.

The applicant provided psychotherapy face-to-face with clients for _____ hours **per week**.

☐ I intend to continue to provide supervision until the registered intern is fully licensed pursuant to Section 491.0045(3), Florida Statutes, and Rule 64B4-3.008, F.A.C. If this status changes before the intern is fully licensed, I will notify the board office in writing of the date I stopped providing supervision.

☐ I am no longer providing this registered intern with supervision as of _____
Month Day Year

Each blank line and one box in this section must be completed.

ONE BOX BELOW MUST BE CHECKED!

As a professional licensee overseeing the supervision of this intern, do you have any information regarding this registered intern's ability to practice and/or counsel independently? Please check one of the following that most closely reflects your opinion as the supervisor overseeing the internship.

☐ Has met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.

☐ Has **not** met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.

If you have chosen "has not met", you must provide further information as to why this requirement has not been met.

_____

Supervisor's Signature **(must be original signature)** Date

This form is to be COMPLETED (not just signed) by the SUPERVISOR!

Florida Department of Health
Division of Medical Quality Assurance •
Board of Clinical Social Work, Marriage &Family Therapy, & Mental Health Counseling
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