Submit form with application, email to info@floridasmentalhealthprofessions.gov, or mail to:

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Verification of Clinical Experience

Form <u>must</u> be completed by the supervisor.

Applicant Name: _____

Florida Intern Registration Number/Other State License Number: _____

Select profession: Clinical Social Work   Marriage & Family Therapy   Mental Health Counseling

1. SUPERVISOR INFORMATION

Supervisor Name: _____

Email Address: _____

License Type	State	License Number

Supervisors licensed outside of Florida must provide a license verification

2. SUPERVISED CLINICAL EXPERIENCE

I have read and understand Rule 64B4-2, Florida Administrative Code (F.A.C.), which states, in part:

An intern shall be credited for the time of supervision required by section (s.) 491.005, Florida Statutes (F.S.), if the intern:
   a) Received at least 100 hours of supervision in no less than 100 weeks; and
   b) Provided at least 1500 hours of face-to-face psychotherapy with clients; and
   c) Received at least one hour of supervision every two weeks

A. Dates of supervision: Start Date: _____   End Date: _____
                                                      MM/DD/YYYY   *Provide specific date* - MM/DD/YYYY

B. The applicant received _____ hours of supervision, with at least one hour of supervision every two weeks.

C. The applicant provided psychotherapy face-to-face with clients for a total of _____ hours.

   Select one of the following:

      I intend to provide supervision until the registered intern is fully licensed pursuant to s. 491.0045(3), F.A.C. If this changes, I will notify the board office of the date supervision ended.

      I am no longer providing this registered intern with supervision as of: _____
                                                                                                                    MM/DD/YYYY

3. SUPERVISOR STATEMENT

As the qualified supervisor of this intern, I affirmatively state that I have complied with all the duties of a qualified supervisor as established in Rule 64B4-2.0025, F.A.C., during the course of the supervision of this applicant.

Supervisor Signature: _____   Date: _____
                                                                                                                                MM/DD/YYYY