

Documentation of Supervision of Marriage and Family Therapy

Notice to applicant: Please complete the first section of this form and mail a copy to each person who provided supervision for at least two years of your clinical experience in marriage and family therapy. Make extra copies of the blank form as needed.

I. TO BE COMPLETED BY THE APPLICANT

Applicant's name _____ SS# _____ - _____ - _____

Address City State Zip

Name of Supervisor _____ Title _____

Location of Supervision _____

Dates of Supervision: From _____ To: _____
Month/Year Month/Year

Number of hours of MFT Supervision: Individual _____ Group _____ Total _____

Description of your clinical practice which was supervised _____

Description of your supervision _____

Oath and Authorization to Release Requested Information

I attest that the above information is a true and accurate representation of my supervision in the clinical practice of marriage and family therapy. Further, I authorize the above-named supervisor to release the requested information.

Applicant's Signature Printed Name Date

II. TO BE COMPLETED BY SUPERVISOR

Please review the applicant’s description of his/her supervision during the clinical practice of marriage and family therapy. 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:

I attest that I am aware of applicant’s supervision experience described on this form and that this description is a true and accurate representation of the supervision of marriage and family therapy I provided for the applicant.

Supervisor’s Signature	Printed Name	Date
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Address	City	State	Zip
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Supervisor’s Discipline	Type of License	License #	State	Expiration Date
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(In the event the above-named person who provided the supervision cannot be located, if the supervision was provided in a training center or other agency, the current supervisor may attest to the supervision based on a review of the available records.)

After a diligent and thorough search of available records, I attest that this applicant’s description of his/her supervision of marriage and family therapy is a true and accurate record of the supervision provided through this office by the above-named supervisor.

Current Supervisor’s Signature	Printed Name	Date
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Name of Agency or Center_____

Address	City	State	Zip	Phone
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Reason supervisor could not be located_____

Please return this completed form to the following Board address:

**Mississippi Board of Examiners for
Social Workers & Marriage and Family Therapists
P. O. Box 4508, Jackson, MS 39296-4508**

