

MARRIAGE AND FAMILY THERAPIST
EXPERIENCE VERIFICATION

1800 37A-301 (REV. 1/00)

400 R ST., SUITE 3150, SACRAMENTO, CA 95814-6240

TELEPHONE: (916)445-4933 TDD: (916)322-1700

WEBSITE ADDRESS: http://www.bbs.ca.gov

Use a separate form for each person verifying hours of supervised experience for licensure as a marriage and family therapist and for each employment setting. No erasures or corrections may be made. If any error has been made, complete a new form. Make certain that the form is complete and correct. Experience verification forms are to be submitted by the applicant with his or her application for licensure. \*The address you enter on this form is public information and will be placed on the Internet pursuant to Business and Professions Code section 27. If you do not want your home or work address available to the public, please provide an alternate mailing address.

BBS File #: Intern #:

I. APPLICANT: (Please type or print clearly in ink.)

1. NAME: Last First Middle
2. \*ADDRESS: Number and Street
City State Zip Code
3. BUSINESS TELEPHONE: 4. RESIDENCE TELEPHONE:

II. SUPERVISOR: (Please type or print clearly in ink.)

1. NAME: Last First Middle
2. ADDRESS: Number and Street
City State Zip Code
3. BUSINESS TELEPHONE:
4. NAME OF APPLICANT'S EMPLOYER:
5. ADDRESS: Number and Street
City State Zip Code
6. BUSINESS TELEPHONE:

7. EMPLOYMENT SETTING:
a. Private practice
b. Governmental entity
c. Nonprofit and charitable corporation (Attach copy of 501(c)(3) tax exempt letter from IRS)
d. School, College, or University
e. Licensed Health Facility as defined by Health and Safety Code Sections 1250, 1250.2, 1250.3, social rehabilitation facility or community treatment facility 1502(a), pediatric day health and respite care facility 1706.2, and a licensed alcoholism or drug abuse recovery or treatment facility 11834.02. (Attach copy of their license)

8. As the supervisor I provided supervision on a:
Self-employed basis in a private practice.
Paid basis by employer
Voluntary basis. Attach the original written agreement between you and the applicant's employer required by Title 16, California Code of Regulations Section 1833(b)(4).

9. Was the applicant receiving pay for the employment? Yes No
If Yes, attach a copy of the applicant's W-2 statement for each year experience is claimed. For the current year in which a W-2 has not been issued, submit a copy of a current paystub.

## II. SUPERVISOR: (Continued)

Applicant's Name: \_\_\_\_\_ BBS File Number: \_\_\_\_\_

10. Dates the experience is being claimed:

From \_\_\_\_\_ To \_\_\_\_\_  
Mo Day Yr Mo Day Yr

11. How many weeks of supervised experience are being claimed?  
\_\_\_\_\_

12. Show only those hours of experience as verified on the weekly summary of hours form.

Logged Hours

- |   |          |
|---|----------|
| a. Individual counseling (No Min. or Max. hrs. Required)  | a. _____ |
| b. Couples, families, and children (Min. 500 hrs.)  | b. _____ |
| c. Group counseling (Max. 500 hrs.)   | c. _____ |
| d. Telephone counseling (Max. 250 hrs.)   | d. _____ |
| e. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes (Max. 250 hrs.) | e. _____ |
| f. Workshops, seminars, training sessions, or conferences (Max. 250 hrs.)   | f. _____ |

**Total** \_\_\_\_\_

13. Face-to-face supervision:

Hours per week      Logged Hours

- |   |       |       |
|---|-------|-------|
| a. <u>Individual</u>  | _____ | _____ |
| b. <u>Group</u> (Group supervision contained no more than 8 persons.) | _____ | _____ |

14. SUPERVISOR:

\_\_\_\_\_  
Type of License

\_\_\_\_\_  
License Number

\_\_\_\_\_  
State of License

\_\_\_\_\_  
Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes  No  Date Board Certified: \_\_\_\_\_

***I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.***

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature