



Board of Behavioral Sciences
 1625 North Market Blvd., Suite S200, Sacramento, CA 95834
 (916) 574-7830
 www.bbs.ca.gov



LICENSED MARRIAGE AND FAMILY THERAPIST IN-STATE EXPERIENCE VERIFICATION

This form is to be completed by the applicant's California supervisor and submitted by the applicant with their *Application for Licensure*. All information on this form is subject to verification.

- Use separate forms for pre-degree and post-degree experience.
- Use separate forms for each supervisor and each employment setting.
- Ensure that the form is complete and correct prior to signing.
- Have the supervisor initial any changes.
- Do not submit *Weekly Log* forms unless specifically requested.

The hours reported on this form were earned (mark one):
 Pre-Degree
 Post-Degree

APPLICANT NAME:

Last	First	Middle	Associate Number AMF
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SUPERVISOR INFORMATION:

Supervisor's Last Name	First	Middle
Business Phone	Email Address	
License Type	License Number	Date First Licensed*

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? N/A No Yes: Date Certified: _____
 Certification Number: _____

**If licensed in California for less than two years on the first date of experience claimed by the applicant, attach your out-of-state license information*

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer		Business Phone	
Address	Number and Street	City	State Zip Code

Applicant: Last	First	Middle
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EMPLOYER INFORMATION (continued):

- Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes No
- Was this experience gained in a private practice or professional corporation setting? Yes No
- Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? Yes No
- For hours gained as an Associate ONLY: Was the applicant receiving pay? Yes No
If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status. N/A (pre-degree experience)

EXPERIENCE INFORMATION:

1. Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy
2. How many weeks of supervised experience are being claimed? _____ Weeks		
3. Hours of Experience:	Logged Hours	
a. Total Direct Counseling Experience (Minimum 1,750 hours)		
• Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? (Minimum 500 of the 1,750 hours)		
b. Total Non-Clinical Experience (Maximum 1,250 hours)		
• Of the above hours, how many were Face-to-Face	Hours Per Week	Logged Hours
Individual or Triadic		
Group (group contained no more than 8 persons)		
<p>NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.</p> <p>Supervisor Signature: _____ Date: _____</p> <p style="text-align: center;">ORIGINAL OR ELECTRONIC SIGNATURE REQUIRED</p>		