LICENCED MARRIAGE AND FAMILY THERAPIST
IN-STATE EXPERIENCE VERIFICATION
OPTION 1 –STREAMLINED METHOD

This form is to be completed by the applicant’s California supervisor and submitted by the applicant with his or her Application for Licensure and Examination. All information on this form is subject to verification.

- Use this “Option 1” form to report hours under the streamlined method
- 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
- Provide an original signature and have the supervisor initial any changes
- Do not submit Weekly Summary forms unless specifically requested

APPLICANT NAME:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Associate Number</th>
</tr>
</thead>
</table>

SUPERVISOR INFORMATION:

<table>
<thead>
<tr>
<th>Supervisor’s Last Name</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Phone</td>
<td>Email Address (OPTIONAL)</td>
<td></td>
</tr>
<tr>
<td>License Type</td>
<td>License Number</td>
<td>Date First Licensed*</td>
</tr>
</tbody>
</table>

- **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: __________ Cert. #: __________
- **LPCCs**: Did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law?  ☐ N/A ☐ No ☐ Yes: Date qualifications were met: ________________

*If licensed in California for less than two years on the first date of experience claimed, provide out-of-state license information.

APPLICANT’S EMPLOYER INFORMATION:

<table>
<thead>
<tr>
<th>Name of Applicant’s Employer</th>
<th>Business Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Number and Street</td>
<td>City State Zip Code</td>
</tr>
</tbody>
</table>

The hours reported on this form were earned (mark one):

 ☐ Pre-Degree
 ☐ Post-Degree
EMployer Information (continued):

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy?  
   □ Yes □ No

2. Was this experience gained in a private practice setting?  
   □ Yes □ No

3. 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

4. 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 Supervision?

   Individual or Triadic

   Group (group contained no more than 8 persons)

   Hours Per Week  Logged Hours

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.

Supervisor Signature: ___________________________ Date: ____________