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

# 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.
- Supervisor must initial any changes.
- Do not submit *Weekly Log* forms unless specifically requested.
- Please see the Notice on Collection of Personal Information *(access at www.bbs.ca.gov>About Us>About the Board>Other Information>Policies).*

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

**APPLICANT NAME:**

| Last | First | Middle | Associate Number AMF |
|---|---|---|---|
| | | | |

| Dates of experience being claimed (mm/dd/yyyy): | From: | To: |
|---|---|---|

**SUPERVISOR INFORMATION:**

| Supervisor's Name | | Email Address *(if supervisor has one)* | |
|---|---|---|---|
| Business Phone | 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*

---

Were you (the supervisor) employed by the supervisee's employer? ☐ Yes ☐ No

If NO, did you and the supervisee's employer sign a written agreement pertaining to oversight of the supervisee? ☐ Yes ☐ No *If YES, applicant must submit a copy of this agreement.*

---

| Applicant: Last | First | Middle |
|---|---|---|
| | | |

**APPLICANT'S EMPLOYER INFORMATION:**

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

| | |
|---|---|
| 1. Was this experience gained in a private practice or professional corporation setting? | ☐ Yes ☐ No |
| 2. <u>For hours gained as an Associate ONLY</u>: Was the applicant receiving pay?<br>*If YES, applicant must submit a copy of their W-2 statement for each year experience is claimed (if a W-2 has not yet been issued for this year, submit a copy of the current paystub).*<br>*If NO (applicant volunteered), applicant must submit a letter from the employer verifying volunteer status.* | ☐ Yes ☐ No<br>☐ N/A (pre-degree experience) |

**EXPERIENCE INFORMATION:**

| 1. Dates of experience (mm/dd/yyyy): | From: | To: |
|---|---|---|

| | |
|---|---|
| 2. Number of weeks of supervised experience: | |
| 3. Hours of Experience: | **Logged Hours** |
| a. Total Direct Clinical Counseling Experience: | |
| • Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? | |
| b. Total Non-Clinical Experience: | |
| • Of the above hours, how many were Face-to-Face Supervision? | **Logged Hours** |
| Individual or Triadic Supervision: | |
| Group Supervision: | |

***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: _____

ORIGINAL OR ELECTRONIC SIGNATURE REQUIRED