



SUPERVISED EXPERIENCE ATTESTATION FORM

Print clearly or type the following information:

Applicant's Name _____ Intern Registration No. _____

Clinical Social Work Marriage & Family Therapy Mental Health Counseling

Supervisor's General Information (to be completed by supervisor)			
Supervisor's Name:		Phone:	
Address:			
License/Certification Title	State	Original Licensure Date	License Number
Other Professional Credential	Organization	Original Certificate Date	Certification Number

Supervised Experience Affirmation (to be completed by supervisor)
<p>I have read and understand Rule Chapter 64B4-2, F.A.C. I provided at least one (1) hour of supervision per fifteen (15) hours of psychotherapy face-to-face with clients provided by the intern, with a minimum of one (1) hour of supervision every two (2) weeks. Supervision was provided from _____ / _____ / _____ to _____ / _____ / _____ for a total of _____ weeks.</p> <p>The applicant provided psychotherapy face-to-face with clients for _____ hours per week.</p> <p align="center"><i>Each blank line in this section must be filled in.</i></p>

ONE BOX BELOW MUST BE CHECKED!

<p>As a professional licensee overseeing the supervision of this intern, do you have any information regarding this registered intern's ability to practice and/or counsel independently? Please check one of the following that most closely reflects your opinion as the supervisor overseeing the internship.</p> <p><input type="checkbox"/> Has met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.</p> <p><input type="checkbox"/> Has not met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.</p> <p>If you have chosen "has not met", you must provide further information as to why this requirement has not been met.</p>

Supervisor's Signature (**must be original signature**) _____ Date _____

This form is to be COMPLETED (not just signed) by the SUPERVISOR!

Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
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