VERIFICATION OF CLINICAL EXPERIENCE

This form must be completed (not just signed) by the supervisor!

Applicant's Name: ____

Florida Intern Registration Number/Other State License Number: ____________________

☐ Clinical Social Work ☐ Marriage & Family Therapy ☐ Mental Health Counseling

Supervisor's General Information		
Supervisor's Name:		**Email:**
License Type	**State**	**License Number**

Supervised Clinical Experience

I have read and understand Rule Chapter 64B4-2, Florida Administrative Code, which states, in part:

An intern shall be credited for the time of supervision required by Section 491.005, F.S., if the intern:

(a) Received at least 100 hours of supervision in no less than 100 weeks; and,

(b) Provided at least 1500 hours of face-to-face psychotherapy with clients; and,

(c) Received at least 1 hour of supervision every two weeks.

Each blank line must be completed.

I provided the applicant with supervision from _____ /_____ /______ to _____ /_____ /______.

The applicant received ________ hours of supervision; with at least 1 hour of supervision every two weeks.

The applicant provided psychotherapy face-to-face with clients for a total of ______________ hours.

Choose one of the following

☐ I intend to provide supervision until the registered intern is fully licensed pursuant to Section 491.0045(3), Florida Statutes, and Rule 64B4-3.008, F.A.C. If this changes, I will notify the board office of the date supervision ended.

☐ I am no longer providing this registered intern with supervision as of: _____ /_____ /______

As the qualified supervisor of this intern, please check the answer below that reflects your opinion of this registered intern's ability to practice and/or counsel independently.

Has the applicant met the minimum standards of performance in professional activities as measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes?

Yes ☐ No ☐

If you chose no, you must provide further information as to why this requirement has not been met.

______________________________ ______________________

Supervisor's Signature **Date**

Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way, Bin C-08
Tallahassee, FL 32399-3258