

Submit form with application, email to info@floridasmentalhealthprofessions.gov, or mail to:

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



Verification of Clinical Experience

Form must be completed by the supervisor.

Applicant Name: _____

Florida Intern Registration Number/Other State License Number: _____

Select profession: Clinical Social Work Marriage & Family Therapy Mental Health Counseling

1. SUPERVISOR INFORMATION

Supervisor Name: _____

Email Address: _____

License Type	State	License Number

Supervisors licensed outside of Florida must provide a license verification

2. SUPERVISED CLINICAL EXPERIENCE

I have read and understand Rule 64B4-2, Florida Administrative Code (F.A.C.), which states, in part:

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

- Received at least 100 hours of supervision in no less than 100 weeks; and
- Provided at least 1500 hours of face-to-face psychotherapy with clients; and
- Received at least one hour of supervision every two weeks

A. Dates of supervision: Start Date: _____ End Date: _____
MM/DD/YYYY Provide specific date - MM/DD/YYYY

B. The applicant received _____ hours of supervision, with at least one hour of supervision every two weeks.

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

Select one of the following:

I intend to provide supervision until the registered intern is fully licensed pursuant to s. 491.0045(3), 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: _____
MM/DD/YYYY

3. SUPERVISOR STATEMENT

As the qualified supervisor of this intern, select the answer below that reflects your conclusion of their 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 s. 491.009(1)(r), F.S.? Yes No

If "No," you must provide further information to explain why this requirement has not been met.

Supervisor Signature: _____ Date: _____

MM/DD/YYYY