

Required for verification of licensed supervision and experience.  
A separate form is required for each board-approved supervisor.

**TEXAS STATE BOARD OF EXAMINERS  
OF MARRIAGE AND FAMILY THERAPISTS  
LICENSED SUPERVISED EXPERIENCE VERIFICATION FORM**

*Mail this correspondence (no fees enclosed) to:*  
**Texas State Board of Examiners of Marriage and Family Therapists**  
**Mail Code 1982, P.O. Box 149347**  
**Austin, Texas 78714-9347**  
Phone: 1-512-834-6657 Fax: 1-512-834-6677

**I. Supervisee Information**

Name: \_\_\_\_\_ Associate License #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

**II. Supervisor Information** *(supervisor must meet the board's criteria)*

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_ Business Phone #: \_\_\_\_\_

Are you a board-approved supervisor?  Yes  No Are you an AAMFT approved supervisor?  Yes  No

**III. Verification of supervision hours**

In the setting described below, I provided the following number of supervision hours to the named supervisee:  
\_\_\_\_\_ # hours individual supervision + \_\_\_\_\_ # hours group supervision = \_\_\_\_\_ total # hours supervision

Of the total number of hours of supervision, how many hours were provided via telephonic or other electronic media?  
\_\_\_\_\_

**IV. Verification of supervised experience hours** - Where were the marriage and family therapy services provided?

Name/address/phone number of agency (practice site #1): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of setting:  Private practice  Hospital  School  Governmental agency  Non-profit  
 Inpatient Treatment Center  Other *(please specify)* \_\_\_\_\_

Dates: From \_\_\_\_\_ (month/day/year) to \_\_\_\_\_ (month/day/year)  
Total years & full months: \_\_\_\_\_

**Total practice hours at this site:** \_\_\_\_\_

Of the total hours of professional services, how many hours were *direct clinical services*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *couples or families*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *individuals*? \_\_\_\_\_

Of the total hours of clinical services to individuals, couples, or families, how many hours were from related experiences that included, but was not limited to work shops, public relations, writing case notes, consulting with referral services, etc.? \_\_\_\_\_

Name/address/phone number of agency (practice site #2): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of setting:  Private practice  Hospital  School  Governmental agency  Non-profit  
 Inpatient Treatment Center  Other (please specify) \_\_\_\_\_

Dates: From \_\_\_\_\_(month/day/year) to \_\_\_\_\_(month/day/year)  
Total years & full months: \_\_\_\_\_

**Total practice hours at this site:** \_\_\_\_\_

Of the total hours of professional services, how many hours were *direct clinical services*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *couples or families*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *individuals*? \_\_\_\_\_

Of the total hours of clinical services to individuals, couples, or families, how many hours were from related experiences that included, but was not limited to work shops, public relations, writing case notes, consulting with referral services, etc.? \_\_\_\_\_

Name/address/phone number of agency (practice site #3): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of setting:  Private practice  Hospital  School  Governmental agency  Non-profit  
 Inpatient Treatment Center  Other (please specify) \_\_\_\_\_

Dates: From \_\_\_\_\_(month/day/year) to \_\_\_\_\_(month/day/year)  
Total years & full months: \_\_\_\_\_

**Total practice hours at this site:** \_\_\_\_\_

Of the total hours of professional services, how many hours were *direct clinical services*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *couples or families*? \_\_\_\_\_

Of the hours of direct clinical services, how many hours were services to *individuals*? \_\_\_\_\_

Of the total hours of clinical services to individuals, couples, or families, how many hours were from related experiences that included, but was not limited to work shops, public relations, writing case notes, consulting with referral services, etc.? \_\_\_\_\_

*If there were more than three practice sites, please attach a separate sheet and list the additional site information.*

**V. Affidavit of Accuracy and Signatures** - By signing this form, I am affirming that all information provided on this form is truthful and accurate.

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisee's Signature

\_\_\_\_\_  
Date

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004).

