Reset Form

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 50710 (R11 / 8-24)

GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B.*** *You must submit proof that you have acquired at least two hundred (200) hours of post-graduate clinical supervision comprised of at least one hundred (100) hours of individual supervision as described in IC 25-23.6-8-2.7. This supervision must be completed in no less than twenty-four (24) months while employed. The supervision must have been provided by a "qualified supervisor" as defined in 839 IAC 1-4-5. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name *(last, first, middle)*	Date of birth *(month, day, year)*
Name of supervisor	Name of business / institution of supervisor
Supervisor title	Business address of supervisor *(number and street, city, state, and ZIP code)*
Applicant's employer during time of supervision	

I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date *(month, day, year)*

SECTION B / SUPERVISOR INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" under IC 25-23.6-8-2.7.*

Name of supervisor *(last, first, middle)*	State license / certificate number / type of license / certificate	
License / Certificate issued by	Name of business / institution of supervisor	Business telephone number ( )
Business address of supervisor *(number and street, city, state, and ZIP code)*		E-mail address
Number of years experience in Marriage and Family Therapy		
Applicant's job during the time of supervision	Applicant's employer during the time of supervision	
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*	
Total number of supervision hours completed	Number of hours of individual supervision	

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

A. I was present at the applicant's place of work.	☐ True	☐ False
B. The applicant's place of work was at a different site but:		
(1) There was an equivalent supervisor on site.	☐ True	☐ False
(2) The applicant was not engaged in independent private practice.	☐ True	☐ False

Brief description of how supervision was conducted:

I affirm that the supervision provided above is true to the best of my knowledge and belief. I affirm that any virtual supervision completed met the definition of "virtual supervision" under IC 25-23.6-8-2.7.

Signature of Supervisor, [please provide your professional credential (i.e., LMFT)]:	Title:
Printed Name of Supervisor:	Date *(month, day, year)*:

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

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SECTION C / AFFIRMATION OF SUPERVISION [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason why the applicant's direct supervisor is no longer able to complete SECTION B.

The applicant's direct supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of supervisor *(last, first, middle, maiden)*	License number

Applicant's job duties during the time of supervision:	Applicant's employer during the time of supervision:
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*
Total number of supervised hours	Number of hours of individual supervision

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of how supervision was conducted

I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete, and correct.

Signature of professional colleague	Date *(month, day, year)*

(Continued on the reverse side.)