

FORM V

Required for verification of licensed supervision and experience

**NORTH DAKOTA MARRIAGE AND FAMILY THERAPY
LICENSURE BOARD**

LICENSED SUPERVISED EXPERIENCE VERIFICATION FORM

Mail this correspondence (no fees enclosed) to:
North Dakota Marriage and Family Therapy Licensure Board
c/o Mallary Schaefer
20 1st St SW
Suite 250
Minot, ND 58701

I. Supervisee Information

Name: _____ Associate License Number: _____
Business Phone: _____ Alternate Phone: _____

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

Name: _____ License Number: _____
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 all settings 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 experience hours

Where were the marriage and family therapy services provided?
Name/address/phone number of agency (practice site): _____

Type of setting: ___ Private practice; ___ Hospital; ___ School; ___ Governmental agency;
___ Non-profit; or ___ other: _____

Dates: From _____ (day/month/year) to _____ (day/month/year) Total years/months: _____

Total Practice hours: _____
_____ Of the total hours of clinical 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 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.?

This page is not applicable. (Check this box and proceed to page 3 if the supervisee practiced in only one setting.)

If services were provided in more than one setting, please complete this section. Practice settings are listed on the supervisory agreement form filed prior to issuance of the associate LMFT license. Attach additional pages as necessary.

Where were the marriage and family therapy services provided?

Name/address/phone number of agency (practice site): _____

Type of setting: ___ Private practice; ___ Hospital; ___ School; ___ Governmental agency;
___ Non-profit; or ___ other: _____

Dates: From _____(day/month/year) to _____(day/month/year) Total years/months: _____

Total Practice hours: _____

_____ Of the total hours of clinical 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 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.?

Where were the marriage and family therapy services provided?

Name/address/phone number of agency (practice site): _____

Type of setting: ___ Private practice; ___ Hospital; ___ School; ___ Governmental agency;
___ Non-profit; or ___ other: _____

Dates: From _____(day/month/year) to _____(day/month/year) Total years/months: _____

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Where were the marriage and family therapy services provided?

Name/address/phone number of agency (practice site): _____

Type of setting: ___ Private practice; ___ Hospital; ___ School; ___ Governmental agency;
___ Non-profit; or ___ other: _____

Dates: From _____(day/month/year) to _____(day/month/year) Total years/months: _____

Total Practice hours: _____

_____ Of the total hours of clinical 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 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.?

III. Total Experience and Supervision Verified

In **all settings** in which supervision and experience is being verified by this form, please provide the following:

Dates: From _____(day/month/year) to _____(day/month/year) Total years/months: _____

Total Practice hours: _____

_____ Of the total hours of clinical 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 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.?

IV. Affidavit of Accuracy and Signature

- Under penalties of perjury, I declare and affirm that the statements made in this affidavit, including any accompanying statements, are true, complete and correct.

Supervisor's Signature

Date