

FORM VI

*Required for verification of supervision or experience accrued in a clinical practicum. (for use from a master's or doctoral program)
To be submitted with application form A*

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

**SUPERVISED CLINICAL PRACTICUM SUPERVISION AND
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: _____ Application Number: _____ (for board use only)
Business Phone: _____ Alternate Phone: _____

II. Supervisor Information

Name: _____ License Number: _____
Academic Institution: _____
Academic Institution Address: _____
Program Department Phone: _____
Supervisor Email Address: _____

Yes No If the applicant is reporting supervision and experience that was accrued during a master's/doctoral program, was the program accredited by the Commission on Marriage and Family Therapy Education (COAMFTE) during the time period in which supervised clinical experience was accrued?

III. Verification of supervision hours

In all settings described below, I provided the following number of supervision hours to the named supervisee in the delivery of marriage and family services during the supervised clinical practicum in a Masters or Doctoral program:

___ # hours individual supervision + ___ # hours group supervision = ___ total # hours supervision

(Note: Although the actual total hours of supervision should be reported, only up to 100 hours of supervision accrued during a supervised clinical practicum may be applied toward licensure as a Licensed Marriage and Family Therapist.)

IV. Verification of experience hours

NOTE: Only up to 500 hours of supervised clinical experience accrued in a **masters or doctoral** program accredited by the Commission on Marriage and Family Therapy Education (COAMFTE) is eligible to apply toward the Licensed Marriage and Family Therapy license requirements. Supervised clinical experience accrued in Masters or other Doctoral programs **cannot be applied** toward licensure as a Licensed Marriage and Family Therapist.

Where were the marriage and family therapy services provided?

Name/address/phone number of agency: _____

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: _____

If more than one practice location during the practicum, please complete the following.

Name/address/phone number of agency: _____

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 Clinical Practicum 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.?

V. Affidavit of Accuracy and Signature.

Under penalties of perjury, I declare and affirm that the statements made in this affidavit, including accompanying statements, are true, complete and correct. I understand that giving the board false information of any kind may result in my prosecution, the voiding of this affidavit, and denial of my licensure.

Supervisor's Signature

Date