STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 WEST ADAMS STREET, SUITE 3600
PHOENIX, AZ 85007
PHONE: 602.542.1882 FAX: 602.364.0890
Board Website: www.azbbhe.us
Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF MFT SUPERVISED WORK EXPERIENCE FORM

IMPORTANT NOTES: Do not submit this form via email unless your supervisee is applying within the next **3** months or has already submitted an application. Rather, provide the form in a sealed envelope to the supervisee. The Board will not hold forms for more than **3** months. ****FOR LMFT LICENSURE SUPERVISEES ONLY**

PART A. Complete the Supervisee Information section.

PART B. Complete the Employer or Supervisor Information section.

PART C. Provide the agency/practice setting name and contact information. Provide a description of the services provided by the supervisee.

PART D. Complete the reporting period start and end date. Do not use CURRENT or PRESENT as the end date. If there are months that clinical supervision was not provided during the reporting period, deduct the hours of work experience acquired in those months.

SUPERVISED WORK EXPERIENCE HOURS

1. **Supervised work experience** = total hours of direct and indirect client services provided during the reporting period (should be the sum of #2 and #6).
2. **Direct client contact** = the performance of therapeutic or clinical functions related to the applicant's professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients.
3. **Direct client contact with couples and families** = the number of direct client contact hours from #2 that involved providing treatment to couples and families.
4. **Direct client contact involving psychoeducation** = #2 minus any psychotherapy hours. Psychoeducation means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health.
5. **Psychoeducation with couples and families** = the number of hours of psychoeducation from #4 that involved couples and families.
6. **Indirect client contact** = training for, and the performance of, functions of an applicant's professional practice level in preparation for or on behalf of a client for whom direct client contact functions are also performed including case consultation and receipt of clinical supervision.

Carefully read the attestations and sign and date the form.

The Employer/Supervisor may submit the form and documentation by email to applications@azbbhe.us, or provide to the supervisee in a sealed envelope with a signature on the seal.

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VERIFICATION OF MFT SUPERVISED WORK EXPERIENCE

PART A. SUPERVISEE INFORMATION

SALUTATION	LEGAL NAME (FIRST NAME LAST NAME)	
☐ MR. ☐ MS. ☐ MRS. ☐ DR.		
CURRENT AZ BOARD LICENSE(S) #	ISSUE DATE(S)	EXPIRATION DATE(S)
EMAIL ADDRESS		PREFERRED PHONE

PART B. EMPLOYER OR SUPERVISOR INFORMATION

SALUTATION	LEGAL NAME (FIRST NAME LAST NAME)	
☐ MR. ☐ MS. ☐ MRS. ☐ DR.		
CURRENT LICENSE(S) # (IF APPLICABLE)	TITLE	PREFERRED PHONE
DURING SUPERVISION I WAS: ☐ OWNER/SUPERVISOR ☐ OTHER (EXPLAIN BELOW) ☐ HIRED FOR SUPERVISED PRIVATE PRACTICE*		EMAIL ADDRESS

**NOTE: other than those hired/approved by the Board to do Supervised Private Practice, a Clinical Supervisor hired outside the agency cannot complete this form.*

PART C. PRACTICE SETTING

AGENCY/PRACTICE NAME			SUPERVISEE'S TITLE OR POSITION
ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	SUPERVISEE WAS AN: ☐ EMPLOYEE ☐ INDEPENDENT CONTRACTOR
DESCRIBE THE SUPERVISEE'S SCOPE OF PRACTICE AND SPECIFIC WORK ACTIVITIES DURING THE PERIOD OF SUPERVISED WORK EXPERIENCE			

Supervisee had ownership in or managed the practice where supervision occurred ☐ YES ☐ NO

PART D. REPORT OF SUPERVISED WORK EXPERIENCE HOURS

REPORTING PERIOD: _____ to _____
Start date *End date*
(do not use "current" or "present")

Was clinical supervision provided throughout the entire time period being verified above? ☐ YES ☐ NO

If NO, do not include work experience hours for the months that supervisee did not receive clinical supervision. Please list the months that clinical supervision was not provided and give an explanation below:

SUPERVISED WORK EXPERIENCE HOURS	
1. Total hours of **supervised work experience** in marriage and family therapy in the reporting period *(direct and indirect)*:	
2. Total hours of **direct client contact** *(from line 1.)* involving psychotherapy and psychoeducation:	
3. Total hours of **direct client contact** *(from line 2.)* with couples and families:	
4. Total hours of **direct client contact** *(from line 2.)* involving psychoeducation *(if applicable):*	
5. Total hours of **psychoeducation** *(from line 4.)* with couples and families *(if applicable)*:	
6. Total hours of **indirect client contact** *(from line 1.)* related to psychotherapy:	

EMPLOYER/SUPERVISOR ATTESTATION

I, _____ (Employer/Supervisor) certify that:

- _____ (Supervisee) was engaged in the supervised practice of marriage and family therapy (including assessment, diagnosis and treatment) that met the Board's requirements as reported above.
- I agree to provide documentation upon request to validate the supervised work experience hours reported above.
- All information contained in this verification, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board not accepting the applicant's supervised work experience hours and/or denying their licensure application.

_____ _____
Signature Date

IMPORTANT: Include a copy of the published job description for the position(s) the supervisee held during the period of work experience reported above.

AGENCY USE ONLY	*RECEIVED DATE*	*STAFF INITIALS*