Verification of Clinical Experience

Form must be completed by the supervisor.

Applicant Name:

Florida Intern Registration Number/Other State License Number:

Select profession: □ Clinical Social Work □ Marriage & Family Therapy □ Mental Health Counseling

1. SUPERVISOR INFORMATION

Supervisor Name:

Email Address:

<table>
<thead>
<tr>
<th>License Type</th>
<th>State</th>
<th>License Number</th>
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Supervisors licensed outside of Florida must provide a license verification

2. SUPERVISED CLINICAL EXPERIENCE

☐ I have read and understand Rule 64B4-2, Florida Administrative Code (F.A.C.), which states, in part:

An intern shall be credited for the time of supervision required by section (s.) 491.005, Florida Statutes (F.S.), if the intern:

a) Received at least 100 hours of supervision in no less than 100 weeks; and

b) Provided at least 1500 hours of face-to-face psychotherapy with clients; and

c) Received at least one hour of supervision every two weeks.

A. Dates of supervision: Start Date: ___________ End Date: ___________

Provide specific date - MM/DD/YYYY

B. The applicant received ________ hours of supervision, with at least one hour of supervision every two weeks.

C. The applicant provided psychotherapy face-to-face with clients for a total of ________ hours.

Select one of the following:

☐ I intend to provide supervision until the registered intern is fully licensed pursuant to s. 491.0045(3), F.A.C. If this changes, I will notify the board office of the date supervision ended.

☐ I am no longer providing this registered intern with supervision as of: ___________

MM/DD/YYYY

3. SUPERVISOR STATEMENT

As the qualified supervisor of this intern, I affirmatively state that I have complied with all the duties of a qualified supervisor as established in Rule 64B4-2.0025, F.A.C., during the course of the supervision of this applicant.

Supervisor Signature: ____________________ Date: ___________

DH-MQA 1181, Revised 5/2021, Rule 64B4-3.0015