



Board of Behavioral Sciences
 1625 North Market Blvd., Suite S200, Sacramento, CA 95834
 Telephone: (916) 574-7830 TTY: (800) 326-2297
 www.bbs.ca.gov



**LICENSED MARRIAGE AND FAMILY THERAPIST
 IN-STATE EXPERIENCE VERIFICATION
 OPTION 1 – NEW STREAMLINED METHOD**

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her *Application for Licensure and Examination*. All information on this form is subject to verification.

- Use this "Option 1" form to report hours under the NEW streamlined method
- Use separate forms for pre-degree and post-degree experience
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing
- Provide an original signature and have the supervisor initial any changes
- Do not submit *Weekly Summary* forms unless specifically requested

The hours reported on this form were earned (mark one): <input type="checkbox"/> Pre-Degree <input type="checkbox"/> Post-Degree
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APPLICANT NAME:

Last	First	Middle	Intern Number IMF
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SUPERVISOR INFORMATION:

Supervisor's Last Name		First	Middle
Business Phone	Email Address (OPTIONAL)		
License Type	License Number	State	Date First Licensed

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? N/A No Yes: Date Certified: _____ Cert. #: _____
- LPCCs: Did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law? N/A No Yes: Date you met the qualifications: _____

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer		Business Phone	
Address	Number and Street	City	State Zip Code

Applicant:	Last	First	Middle
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EMPLOYER INFORMATION (continued):

- Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes No
- Was this experience gained in a private practice setting? Yes No
- Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? Yes No
- For hours gained as an Intern ONLY: Was the applicant receiving pay? Yes No
If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status. N/A (pre-degree experience)

EXPERIENCE INFORMATION:

1. Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy
2. How many weeks of supervised experience are being claimed? _____ weeks		
3. Hours of Experience:		Logged Hours
a. Total Direct Counseling Experience (Minimum 1,750 hours)		
• Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? (Minimum 500 of the 1,750 hours)		
b. Total Non-Clinical Experience (Maximum 1,250 hours)		
• Of the above hours, how many were Face-to-Face Supervision?		
	Hours Per Week	Logged Hours
Individual		
Group (group contained no more than 8 persons)		

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Signature of Supervisor: _____ Date: _____