**LICENSED MARRIAGE AND FAMILY THERAPIST**

**IN-STATE EXPERIENCE VERIFICATION**

**OPTION 1 – 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 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

### APPLICANT NAME:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Associate Number</th>
</tr>
</thead>
</table>

### SUPERVISOR INFORMATION:

<table>
<thead>
<tr>
<th>Supervisor’s Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Business Phone</th>
<th>Email Address (OPTIONAL)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Number</th>
<th>Date First Licensed*</th>
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</thead>
</table>

- **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 qualifications were met: ___________

*If licensed in California for less than two years on the first date of experience claimed, provide out-of-state license information.

### APPLICANT’S EMPLOYER INFORMATION:

<table>
<thead>
<tr>
<th>Name of Applicant’s Employer</th>
<th>Business Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Number and Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>
**EMPIRE INFORMATION (continued):**

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy?  
   - Yes  
   - No

2. Was this experience gained in a private practice setting?  
   - Yes  
   - No

3. 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

4. For hours gained as an Associate ONLY: Was the applicant receiving pay?  
   - Yes  
   - No  
   - N/A (pre-degree experience)

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**EXPERIENCE INFORMATION:**

1. Dates of experience being claimed:  
   - From: _______________  
   - To: _______________  
   - mm/dd/yyyy  
   - 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?

   Individual or Triadic

   Group (group contained no more than 8 persons)

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**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.

Supervisor Signature: ___________________________________________  
Date: _________________