VERIFICATION OF FACE TO FACE CLIENT CONTACT

Notice to Applicant: Please complete the first section of this form and send a copy to the director or supervisor of each practice site or agency in which you practiced social work during supervision. You need documentation of at least a minimum of one-thousand (1000) hours of face to face client contact.

I.**TO BE COMPLETED BY THE APPLICANT**

Applicant's Name _____ License # _____

Email Address: _____

Address _____
Street City State Zip Phone

Practice Site or Agency_____

Address _____
Street City State Zip Phone

Position/Title _____

Description of Responsibilities _____

_____

Dates of Supervision: From _____ To _____
Month/Year Month/Year

Total weeks of supervision at this site: _____ Average clinical hours per week _____

Total client contact hours during supervision: Individual _____ Group _____ Total hours _____

Oath and Authorization to Release
I attest that the above information is a true and accurate representation of my experience in the clinical practice of social work at the above site. Further, I authorize the above agency, director or supervisor to release the requested information.

_____
Signature of Licensee Printed Name Date

Continued on reverse side

II. TO BE COMPLETED BY PRACTICE SITE DIRECTOR OR SUPERVISOR

Please review the applicant's description of his/her clinical practice of social work at your site/agency. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide that information below:

_____

_____

_____

I attest that I served as (please indicate) director or supervisor for the applicant during the clinical experience described above and that this description is a true and accurate representation of the applicant's clinical experience in marriage and family therapy at this site.

_____
Director or Supervisor's Signature Printed Name Date

Name of Site_____ Phone _____

_____
Address City State Zip

(If the director or supervisor who worked with the applicant cannot be located, the current director or supervisor may verify the applicant's experience based on a review of the available records.)

After a diligent and thorough search of available records, I attest that this description is a true and accurate record of this applicant's clinical experience in marriage and family therapy at this site.

_____
Director or Supervisor's Signature Printed Name Date

Name of Site_____ Phone _____

_____
Address City State Zip

Please return this completed form directly to MBOE via email to the Social Work Licensing Officer or mail to the following Board address:

Mississippi Board of Examiners for
Social Workers & Marriage and Family Therapists
P.O. Box 4508 ! Jackson, MS 39296-4508