BOARD OF EXAMINERS
P.O. BOX 4508
Jackson, MS 39296-4508
Phone (601)987-6806/Fax (601)987-6808
www.swmft.ms.gov
info@swmft.ms.gov

# Verification of Post-Degree Experience in the Clinical Practice of Marriage & Family Therapy

**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 marriage and family therapy following the receipt of the master's or doctoral degree in marriage and family therapy. You need documentation of at least two years of experience with a minimum of ten (10) hours of marriage and family therapy per week.

## I. TO BE COMPLETED BY THE APPLICANT

Applicant's Name _______ SS#/Alien Registration# _____ -____-_____

Address _____
Street City State Zip

Phone _____ Email_____

Practice Site or Agency_____

Address _____
Street City State Zip

Phone _____

Position/Title _____

Description of Responsibilities _____
_____
_____
_____

Dates of Practice (Month/Year): From _____ To _____

Total weeks of practice at this site: _____ Average MFT clinical hours/week:_____

Total clinical hours at this site: Individual _____ Groups _____ Couples/Families _____

**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 marriage and family therapy at the above site. Further, I authorize the above agency, director or supervisor to release the requested information to the MS Board of Examiners for Social Workers and Marriage and Family Therapists.

_____ _____ _____
Signature of Applicant Printed Name Date

## II. TO BE COMPLETED BY SUPERVISOR

Please review the applicant's description of his/her clinical practice of marriage and family therapy 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.

_____ _____ _____

Current Director or Supervisor's Signature Printed Name Date

Name of Site_____ Phone _____

_____

Address City State Zip

*Please return this completed form directly to the Board at the address above.*