

IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE & FAMILY THERAPISTS

Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise, ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
Phone: (208) 334-3233 Website: <https://dopl.idaho.gov>
E-mail: cou@dopl.idaho.gov

MFT EVALUATION AND VERIFICATION OF SUPERVISED EXPERIENCE APPLICATION

The Applicant named below is seeking licensure to practice Marriage & Family Therapy in the State of Idaho. The Idaho Board requires the information below in order to evaluate the extent and quality of the applicant's supervised experience.

SECTION 1 - To be completed by applicant & reviewed by the named supervisor: (this page must be submitted to Supervisor with page 2). Please keep a copy for your records. DO NOT submit supervision logs unless requested.

A. Name of supervisor _____

B. Applicant's supervised practice location (facility name and address):

C. Supervisor Contact Phone Number (____) _____

D. Supervised hours: (**check only one**):

INTERNSHIP / PRACTICUM / GRADUATE **POST-GRADUATE**

E. Dates of practice by applicant at this setting: from _____ to _____

F. Total number of direct and indirect hours during period listed in E above: _____

1. Number of direct client contact hours included in F above: _____

2. Number of direct contact hours with couples, families and other systems included in F1 above: _____

Other systems refers to two or more people who are working on a relationship. It might be a couple, parent and child, siblings, employee and boss, co-workers. This question refers to situations where applicants have supervised experience with two or more people in the room.

G. Supervision hours during period listed in D above:

1. Individual (not group): Number of hours _____

2. Group supervision: Number of hours _____

H. Please describe the nature of the applicant's duties:

Printed Name of Applicant

Signature of Applicant

EVALUATION AND VERIFICATION OF SUPERVISED EXPERIENCE

(continued)

SUPERVISOR INFORMATION

SECTION 2 - To be completed by the supervisor: (do not complete without reviewing Section 1- if the hours are entered incorrectly the hours will not be accepted)

Title at time of supervision _____

Title of professional license, if held _____

State of License _____ Professional License Number _____

I attest that during the time I was providing supervision to this candidate, I was a registered supervisor with the Idaho State Licensing Board of Professional Counselors and Marriage & Family Therapists. () YES () NO

Applicant's supervised practice location (facility name and address):

H. Please state the quality of the applicant's performance during the supervised practice period:

I. I have reviewed the applicants hours and they () are **or** () are not substantially correct.
(If the supervision/contact hours are not correct the hours will not be accepted.)

J. I have reviewed the applicant's statements. They () are **or** () are not substantially correct.

K. As supervisor, do you have any reservations about the applicant being granted a license? () YES () NO

IF **YES**, PLEASE SPECIFY (Attach additional sheet if necessary):

AFFIDAVIT

I hereby certify under penalty of perjury that the responses provided by both the applicant and myself are true and accurate to the best of my knowledge and belief, and that I may be required to provide additional information. I further certify that I have reviewed and will comply with the Idaho Laws and Rules, including the adopted Code of Ethics, governing supervision and the practice of Counseling and/or Marriage & Family Therapy.

Printed Name of Supervisor

Signature of Supervisor

NOTICE TO SUPERVISOR

Please be aware this document will become part of the applicant's file, and the applicant has the right to request anything from the file.

To accept all reported hours of supervised experience as valid, these forms may be submitted using the following methods:

SCAN AND EMAIL – The supervisor signing these forms may scan and email them to cou@dopl.idaho.gov. If the license applicant is scanning and emailing the documents, please ensure that the signing supervisor is cc'd on the email submission.

MAILING YOUR DOCUMENTS - Please seal BOTH PAGES of this completed document in an envelope, sign your name across the sealed back flap, and return it to the applicant.

Addendum for Marriage and Family Therapy Supplemental Practicum Hours

Supplemental hours are post-masters hours only (see Rule 10 and Rule 230)

SECTION 1 - To be completed by applicant & reviewed by the named supervisor: (this page must be submitted to Supervisor with page 2). Please keep a copy for your records.

A. Applicant name: _____

B. Name of supervisor (Must be a LMFT) _____

C. Applicant's supervised practice location (facility name and address): _____

D. Phone number of supervisor (_____) _____

E. The supervision was (mark with an X **one only**):

IDAHO REGISTERED INTERN **SUPERVISED PRACTICE OTHER JURISDICTION**
Registered intern number _____

F. Dates of practice by applicant at this setting: from _____ to _____

G. Total number of direct client contact hours during the period listed in F above: _____

- Number of direct contact hours with families, couples and other systems included in F above _____
Other systems refers to two or more people who are working on a relationship. It might be a couple, parent and child, siblings, employee and boss, co-workers.
This question refers to situations where applicants have supervised experience with two or more people in the room.

H. Number of individual **supervision hours** (not group) hours with supervisor during period listed in E above:

(Required ratio 1 hour of supervision for every 10 hours of direct client contact)

Number of hours in person _____ Number of hours live electronic connection _____

I. Please describe the nature of the applicant's duties:

Printed Name of Applicant

Signature of Applicant

Supplemental Practicum Hours
(continued)

SECTION 2 - To be completed by the supervisor: (do not complete without reviewing Section I)

State of License _____ LMFT License Number _____

Applicant's supervised practice location (facility name and address):

I. I have reviewed the applicant's statements. They are **or** are not substantially correct.

J. As supervisor, do you have any reservations about the applicant being granted a license? yes no
If yes, please specify (attached additional sheet if necessary):

AFFIDAVIT

I hereby certify under penalty of perjury that the responses provided by both the applicant and me are true and accurate to the best of my knowledge and belief, and that I may be required to provide additional information. I further certify that I have reviewed and will comply with the Idaho Laws and Rules, including the adopted Code of Ethics, governing supervision and the practice of Counseling and/or Marriage & Family Therapy.

Printed Name of Supervisor

Signature of Supervisor

NOTICE TO SUPERVISOR

Please be aware this document will become part of the applicant's file, and the applicant has the right to request anything from the file.

To accept all reported hours of supervised experience as valid, these forms may be submitted using the following methods:

SCAN AND EMAIL – The supervisor signing these forms may scan and email them to cou@dopl.idaho.gov. If the license applicant is scanning and emailing the documents, please ensure that the signing supervisor is cc'd on the email submission.

MAILING YOUR DOCUMENTS - Please seal BOTH PAGES of this completed document in an envelope, sign your name across the sealed back flap, and return it to the applicant.