COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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QUARTERLY EVALUATION FOR LMFT LICENSURE

Section 115-50-60-D-1 of the Virginia LMFT regulations requires that the applicant's supervisor provide quarterly evaluations to the resident. This form must be signed and dated by the supervisor. **This form is to be completed by the supervisor each quarter and provided to the resident to be held in their possession until they are ready to submit their licensure application.**

Name of Applicant (Last, First, Middle)	Applicant's Email Address

SUPERVISOR'S EVALUATION:

Supervisor's Name (Last, First)	License Number:	License Type:
Business Name and Address of Residency Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)		
Dates of supervision: From (mm/dd/yy): _____	To (mm/dd/yy): _____	

All Columns Must Be Completed	Hours per week	Total hours	Hours are duplicated on another supervisor's quarterly form
Total hours of supervised residency (face-to-face client contact hour + ancillary hours)			Yes No
How many Face-to-face Client Contact hours did the resident provide?			Yes No
How many face-to-face client contact hours were with Couples and Families or Both?			Yes No
How many Individual Supervision hours did the resident receive?			
How many Group Supervision hours did the resident receive?			
If applicable, Total number of face-to-face client contact hours in clinical substance abuse treatment services.			Yes No

These areas are outlined in Section 18 VAC 115-50-55 of the LMFT Regulations. The resident must have supervised residency in the **role of a marriage and family therapist** in the below areas.

Did the applicant provide clinical marriage and family services in the below core areas while under your direct supervision? • Marriage and Family Studies • Marriage and Family Therapy • Human Growth and Development Across the Lifespan • Abnormal Behaviors • Diagnosis and Treatment of Addictive Behaviors • Multicultural Counseling • Professional Identity • Research • Assessments and Treatment	Yes No If no, explain on a separate page.
Do you have any concerns about the competency of the resident? If yes, explain on separate page.	Yes No
Supervisor's Signature:_____	Date:_____