COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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VERIFICATION OF CLINICAL SUPERVISION FOR LMFT LICENSURE

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY			
Name of Applicant (Last, First, Middle)	Applicant's Email Address		
SUPERVISOR'S EVALUATION:			
Supervisor's Name (Last, First)	License Number:	License Type:	Supervisor's Telephone Number
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): _____ Total Months:_____			

Did the resident receive a minimum of one (1) hour and a maximum of four (4) hours of in-person supervision per 40 hours of work experience while under your **direct supervision**?	Yes No If no, explain on separate page	
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
Did the applicant complete a minimum of 3,400 hours of supervised residency in the role of marriage and family therapist under your **direct supervision**? If not, how many? _____	Yes No	
Did the resident complete at least 2,000 hours of face-to face client contact in providing clinical marriage and family services under your **direct supervision**? If not how many? _____	Yes No	
Did the resident complete at least 1,000 hours of face-to face client contact with couples or families or both under your **direct supervision**? If not how many? _____	Yes No	
Did the applicant demonstrate minimum competencies in the following 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 separate page	
In your opinion has the applicant demonstrated competency sufficient for licensing and the independent practice in marriage and family services? If not, explain on separate page.	Yes No	

I declare that, to the best of my knowledge, the foregoing is true and correct. This evaluation has been discussed with the resident and a copy has been provided to the resident.

Supervisor Signature:_____ Date:_____