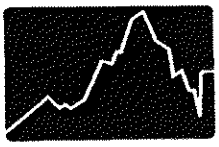

Commonwealth of Virginia
Board of Counseling

Licensure by Examination – Step Two

MFT FORM 2-VS

Photocopy This Form As Needed

VERIFICATION OF SUPERVISION

Post-Graduate Degree Supervised Experience

This form is to be **filled out by the supervisor** when the resident's supervision is completed. Include this form with your application in a separate, sealed envelope with the supervisor's signature across the seal. Complete all sections in Part One and **have your supervisor complete Part Two.** Quarterly Evaluations must accompany your MFT application (unless you are applying by endorsement).

PART ONE – TO BE COMPLETED BY THE APPLICANT

Applicant's Name (Last, First, Middle)

Supervisor's Name (Last, First, Middle)

Supervisor's License Number **License Type**

Date License Issued **Date of Expiration** **Issued in State of:**

PART TWO – TO BE COMPLETED BY THE SUPERVISOR

After completing return to resident in a sealed envelope with your signature across the flap.

Supervision was given to resident from (mm/dd/yy) through (mm/dd/yy)

DESCRIPTION OF COUNSELING SERVICES RENDERED BY RESIDENT UNDER YOUR SUPERVISION

1. Name and address where the clinical hours were obtained: _____

2. Is setting non-profit? YES NO

3. In your opinion, has the applicant demonstrated competency in counseling practice sufficient for licensing and the independent practice of marriage & family therapy? YES NO

Please elaborate:

Both Columns Must Be Completed	Hours/Wk	Total Hrs
How many hours of **experience** did the resident obtain under your supervision?		
How many hours of **direct client contact** did the resident obtain under your supervision?		
How many hours of **direct client contact** did the resident obtain **with couples & families?**		
How many hours of **individual supervision** did you provide the resident?		
How many hours of **group supervision** did you provide the resident?		

VERIFICATION OF SUPERVISION – CONTINUED

Your evaluation of the resident's competencies and the areas covered in supervision is required. To complete supervision requirements the resident must have satisfied all items listed below in one or more supervisory experiences during 4,000 hours of counseling experience. Please place an "X" in the column that represents your evaluation of competencies.

YES = The applicant has satisfactorily demonstrated competencies in this area **NO** = Additional work is required to achieve competency **DNI** = Supervision did not include this area

MARRIAGE & FAMILY COMPETENCIES	YES	NO	DNI
Marriage & Family Systems Theories:			
Marriage & Family Therapy Therapeutic Interventions:			
Human Development:			
TREATMENT PLANNING & IMPLEMENTATION			
Demonstrates an ability to diagnose client's problems using appropriate methods and can justify the treatment plan based on case information.			
PROFESSIONAL IDENTITY & FUNCTION	YES	NO	DNI
Uses supervision and shows continuing development of counseling skills.			
Demonstrates knowledge of strengths and limitations of an MFT and the distinctive contributions of other mental health and health professionals.			
Makes appropriate referrals to other health providers and resources in the community.			
Handles appropriately, or knows how to handle, psychiatric emergencies.			
PROFESSIONAL ETHICS & STANDARDS OF PRACTICE	YES	NO	DNI
Understands and has discussed ethical issue concerning dual relationships.			
Knows the laws related to a counselor's duty in life-threatening situations, child & physical abuse, etc.			
Understands and has discussed the ethics of confidentiality and other legal and ethical issues.			
CASE MANAGEMENT AND RECORDKEEPING	YES	NO	DNI
Maintains appropriate clinical records and client data.			
Understands circumstances under which various records can be released.			

THIS EVALUATION HAS BEEN DISCUSSED WITH THE RESIDENT AND A COPY HAS BEEN PROVIDED TO THE RESIDENT.

Signature of Supervisor: _____ Date: _____

Commonwealth of Virginia
Board of Counseling

Licensure by Examination – Step Two

MFT FORM 2-VS

Photocopy This Form As Needed

VERIFICATION OF SUPERVISION

Post-Graduate Degree Supervised Experience

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PART ONE – TO BE COMPLETED BY THE APPLICANT

Applicant's Name (Last, First, Middle)

Supervisor's Name (Last, First, Middle)

Supervisor's License Number **License Type**

Date License Issued **Date of Expiration** **Issued in State of:**

PART TWO – TO BE COMPLETED BY THE SUPERVISOR

After completing return to resident in a sealed envelope with your signature across the flap.

Supervision was given to resident from (mm/dd/yy) through (mm/dd/yy)

DESCRIPTION OF COUNSELING SERVICES RENDERED BY RESIDENT UNDER YOUR SUPERVISION

1. Name and address where the clinical hours were obtained: _____

2. Is setting non-profit? YES NO

3. In your opinion, has the applicant demonstrated competency in counseling practice sufficient for licensing and the independent practice of marriage & family therapy? YES NO
   Please elaborate:

Both Columns Must Be Completed	Hours/Wk	Total Hrs
How many hours of **experience** did the resident obtain under your supervision?		
How many hours of **direct client contact** did the resident obtain under your supervision?		
How many hours of **direct client contact** did the resident obtain **with couples & families**?		
How many hours of **individual supervision** did you provide the resident?		
How many hours of **group supervision** did you provide the resident?		

VERIFICATION OF SUPERVISION – CONTINUED

Your evaluation of the resident's competencies and the areas covered in supervision is required. To complete supervision requirements the resident must have satisfied all items listed below in one or more supervisory experiences during 4,000 hours of counseling experience. Please place an "X" in the column that represents your evaluation of competencies.

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Marriage & Family Therapy Therapeutic Interventions:			
Human Development:			
TREATMENT PLANNING & IMPLEMENTATION			
Demonstrates an ability to diagnose client's problems using appropriate methods and can justify the treatment plan based on case information.			
PROFESSIONAL IDENTITY & FUNCTION	YES	NO	DNI
Uses supervision and shows continuing development of counseling skills.			
Demonstrates knowledge of strengths and limitations of an MFT and the distinctive contributions of other mental health and health professionals.			
Makes appropriate referrals to other health providers and resources in the community.			
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Understands and has discussed the ethics of confidentiality and other legal and ethical issues.			
CASE MANAGEMENT AND RECORDKEEPING	YES	NO	DNI
Maintains appropriate clinical records and client data.			
Understands circumstances under which various records can be released.			

THIS EVALUATION HAS BEEN DISCUSSED WITH THE RESIDENT AND A COPY HAS BEEN PROVIDED TO THE RESIDENT.

Signature of Supervisor: _____ Date: _____