Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov

LICENSED MARRIAGE AND FAMILY THERAPIST
IN-STATE EXPERIENCE VERIFICATION
OPTION 1 –STREAMLINED METHOD

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her *Application for Licensure and Examination*. All information on this form is subject to verification.

- Use this "Option 1" form to report hours under the streamlined method
- Use separate forms for pre-degree and post-degree experience
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing
- Provide an original signature and have the supervisor initial any changes
- Do not submit *Weekly Summary* forms unless specifically requested

The hours reported on this form were earned (mark one):
☐ Pre-Degree
☐ Post-Degree

APPLICANT NAME:

Last	First	Middle	Associate Number AMF

SUPERVISOR INFORMATION:

Supervisor's Last Name	First	Middle

Business Phone	Email Address (OPTIONAL)

License Type	License Number	Date First Licensed*

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ N/A ☐ No ☐ Yes: Date Certified: _____ Cert. #: _____
- LPCCs: Did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law? ☐ N/A ☐ No ☐ Yes: Date qualifications were met: _____

**If licensed in California for less than two years on the first date of experience claimed, provide out-of-state license information.*

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer	Business Phone

Address Number and Street	City	State	Zip Code

Applicant: Last	First	Middle

EMPLOYER INFORMATION *(continued)*:

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? ☐ Yes ☐ No

2. Was this experience gained in a private practice setting? ☐ Yes ☐ No

3. Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? ☐ Yes ☐ No

4. For hours gained as an Associate ONLY: Was the applicant receiving pay? ☐ Yes ☐ No

   If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status.

   ☐ N/A (pre-degree experience)

EXPERIENCE INFORMATION:

1. Dates of experience being claimed:	From: _____ *mm/dd/yyyy*	To: _____ *mm/dd/yyyy*

2. How many weeks of supervised experience are being claimed? _____ weeks

3. Hours of Experience:		**Logged Hours**
a. Total Direct Counseling Experience *(Minimum 1,750 hours)*		
• Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? *(Minimum 500 of the 1,750 hours)*		
b. Total Non-Clinical Experience *(Maximum 1,250 hours)*		
• Of the above hours, how many were Face-to-Face Supervision?	**Hours Per Week**	**Logged Hours**
Individual or Triadic		
Group (group contained no more than **8** persons)		

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Supervisor Signature: _____ Date: _____