



## APPLICATION FOR LICENSURE AS A ASSOCIATE PROFESSIONAL COUNSELOR

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND  
MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive, Macon, Georgia 31217

Phone (478) 207-2440 \* [www.sos.state.ga.us/plb/counselors](http://www.sos.state.ga.us/plb/counselors)

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Professional Counseling in the State of Georgia. Visit the following web site for information:

<http://www.sos.state.ga.us/plb/counselors>

### **\*\*Important\*\***

**The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year and you will have to reapply.**

### **Application Checklist**

**The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.**

The **NON-REFUNDABLE APPLICATION FEE** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule at the Board's website)

- NOTARIZED APPLICATION:** The application must be mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation at their next scheduled meeting. Approval of licensure is at the Board's discretion.
- NATIONAL BOARD SCORES:** All applicants are required to pass the **either** the National Counselor Examination (NCE) **OR** the National Clinical Mental Health Counseling Examination (NCMHCE) offered by the National Board for Certified Counselors (NBCC). If you have taken one of these exams, please contact the National Board's administrative offices at (336) 547-0607 and have them certify your scores to Georgia. You must submit the exam fee directly to NBCC, do not include fee with your application.
- DEGREE TRANSCRIPT:** All applicants for licensure must have graduated with a master's degree primarily counseling in content from an institution accredited by a regional body recognized by the Council on Higher Education Accreditation. An **official** college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school.
- NAME CHANGE:** IF YOUR NAME HAS CHANGED SINCE YOU ATTENDED SCHOOL, please make a note on the application advising of your former name(s) so we can match the documents with your application.

- FORM A/INTERNSHIP SUPERVISION VERIFICATION:** The instructor of record at the college or university or the Site Supervisor may provide verification of the Internship which was part of your graduate degree program.
- OTHER STATE LICENSURE CERTIFICATION:** If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board's office.
- CONTRACT AFFIDAVIT:** Please submit the four page contract affidavit with documentation completed by your Employer (Director) and Supervisor (the person who will be providing the clinical review training). The Training Experience and Plan for Direction as well as the Plan for Supervision must be documented.
- REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with your experience in Professional Counseling.
- IMPORTANT:** Applicants, please note when accessing your application status on our website under the *Online Services* category *Check the Status of an Application*, that checklist items that have been moved over to the completed column only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process. Please allow several days after submission of documents before checking the status online.

Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists have the authority to approve or deny an application for licensure. **Every application file must be submitted to the Board for review.** The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board's decision within five to seven working days after the Board meeting.

**PLEASE DO NOT INCLUDE THESE INSTRUCTIONS WITH YOUR APPLICATION BELOW, AND SUPPORTING DOCUMENTS, WHEN MAILING IT IN**



PART II - POST-MASTER'S DIRECTED EXPERIENCE UNDER SUPERVISION

INSTRUCTIONS:

- The number of years of Post-Master's Directed Experience under Supervision required for licensure as a Professional Counselor **depends on the graduate degree that you hold**. See Board Rule 135-5-.02(b) 2.
- Complete below.

- I have completed and am submitting as part of this Application the Post-Master's Directed Experience Under Supervision Contract and Affidavit
- I acknowledge that if I change work settings, contract terms or supervisors, I must request and receive approval from the Board by completing a new contract and submitting it to the Board for approval.

PART III - PROFESSIONAL BACKGROUND

ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.

- Yes  No      1.      Are you unable to practice safely as a result of use of alcohol or other drugs?
- Yes  No      2.      Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
- Yes  No      3.      Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?
- Yes  No      4.      Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- Yes  No      5.      Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- Yes  No      6.      To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- Yes  No      7.      Have you ever been convicted of any criminal offense?
- Yes  No      8.      Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the "Georgia First Offenders Act"? You must respond, "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.
- Yes  No      9.      Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- Yes  No      10.     Do you now hold or have you ever held a license as a social worker in any jurisdiction? If "yes" complete the following:  
Jurisdiction \_\_\_\_\_ License No. \_\_\_\_\_  
Date Issued \_\_\_\_\_ Expiration \_\_\_\_\_
- Yes  No      11.     Have you previously applied for the same license for which you are currently applying? If "yes" name under which application was submitted: \_\_\_\_\_
- Yes  No      12.     Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

**PART IV – GRADUATE EDUCATION**

INSTRUCTIONS:

- Complete this part for the graduate degree that you want the Board to consider as part of this application.
- List any additional courses you want considered as part of this Application.
- Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

**DEGREE**

Ph.D.       Master’s – Specialist       Master’s       Master’s – Rehabilitation Counseling

Date Awarded:

Program/Major:

Name of Institution:

Street Address:

City/State/Zip:

**ADDITIONAL COURSEWORK**

COURSE TITLE AND NUMBER	INSTITUTION

**PART V – REQUIRED COURSEWORK**

INSTRUCTIONS:

- List the titles and numbers of courses from your transcript(s) which satisfy the professional counseling content area requirements.
- This must be graduate level coursework from an accredited institution, **either as part of the degree program, or** as additional coursework completed **prior to, during or after the degree program** to demonstrate that the degree is **primarily counseling in content or in a program of applied psychology**.
- Have the Instructor of Record/Supervisor of your Practicum/Internship course complete Form A.
- See Board Rule Chapter 135-5-.02(b)

**COUNSELING/PSYCHOTHERAPY THEORY**

INSTITUTION	COURSE #	COURSE TITLE

**COUNSELING OR APPLIED PSCHOLOGY PRACTICUM OR INTERNSHIP**


**SIX (6) OF THE FOLLOWING EIGHT (9) CONTENT AREAS**

***I - HUMAN GROWTH AND DEVELOPMENT***


<b>II - SOCIAL AND CULTURAL FOUNDATIONS OR CORE FOUNDATIONS</b>		
<b>III - THE HELPING RELATIONSHIP OR ADVANCED PSYCHOTHERAPY/INTERVENTION THEORY</b>		
<b>IV - GROUP DYNAMICS AND GROUP COUNSELING/PSYCHOTHERAPY</b>		
<b>V - LIFESTYLE AND CAREER DEVELOPMENT</b>		
<b>VI - APPRAISAL/ASSESSMENT OF INDIVIDUALS</b>		
<b>VII - RESEARCH METHODS AND EVALUATION OR RESEARCH STATISTICS</b>		
<b>VIII - PROFESSIONAL ORIENTATION</b>		
<b>IX PSYCHOPATHOLOGY</b>		



**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS.  
RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

**Printed Name**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

\_\_\_\_\_ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at:

<http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_ A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_ In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS  
 237 Coliseum Drive, Macon, Georgia 31217-3858  
 (478) 207-2440 [Telephone] \* [www.sos.state.ga.us/plb/counselors](http://www.sos.state.ga.us/plb/counselors)

**ASSOCIATE PROFESSIONAL COUNSELOR PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION  
 FORM A**

**INSTRUCTIONS:** Please type or print clearly. **NO FAXED FORMS ACCEPTED**

**APPLICANTS;**

- Complete Part I and submit to your Practicum/Internship Supervisor. See Board Rule Chapter 135-5-.02(2)5.
- If you have more than one practicum or internship, submit a form for each. You may photocopy this form.

**PRACTICUM/INTERNSHIP SUPERVISOR:**

Complete Part II, noting requirements. Please enclose this form in a sealed envelope. Sign your name over the flap and then either mail it to the applicant or send it directly to the Board office. Fax copies are not acceptable.

**The Practicum/Internship must:**

- Be part of the master's degree program. Be in Professional Counseling or in Applied Psychology before January 1, 2004.
- Include a minimum of 300 hours in the practice of counseling under supervision.

**The Practicum/Internship Supervisor must:**

- **Be the Instructor of Record at the college or university or the Site Supervisor; and**
- Be licensed – as a Professional Counselor, Clinical Social Worker, Marriage and Family therapist, Psychologist, Psychiatrist – or be a Certified Rehabilitation Counselor. See Board Rule Chapter 135-5-1(a) 5 for further details.

**PART I – APPLICANT**

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**PART II – SUPERVISOR**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
 Street City State  
 Zip Code

TELEPHONE: ( ) FAX: ( )

TYPE OF LICENSE:  Professional Counselor  Clinical Social Worker  Marriage and Family Therapist  Psychologist  
 Psychiatrist  Certified Rehabilitation Counselor

LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_

**CERTIFICATION OF SUPERVISION:**

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced Professional Counseling work at:

NAME OF PRACTICUM/INTERNSHIP SITE: \_\_\_\_\_  
 FROM: \_\_\_\_\_ TO: \_\_\_\_\_ FOR A TOTAL OF \_\_\_\_\_ HOURS.  
 MONTH/YEAR MONTH/YEAR # HOURS

DESCRIBE THE PRACTICE SUPERVISED:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VERIFICATION:** I attest that I provided the supervision described above and that this is a true and accurate representation of this supervision.

Date \_\_\_\_\_ Signature of Supervisor/Instructor of Record \_\_\_\_\_

Sworn to and subscribed before me this  
 \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public  
 My commission Expires: \_\_\_\_\_

NOTARY SEAL



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**ASSOCIATE PROFESSIONAL COUNSELOR  
 PRACTICUM/INTERNSHIP – MISSING OR DECEASED SUPERVISOR AFFIDAVIT  
 FORM B**

**INSTRUCTIONS:** Please type or print clearly. **NO FAXED FORMS ACCEPTED**

**APPLICANTS:**

- Make every effort to locate the supervisor(s)/instructor of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor(s), you may attest to undocumented supervision of practicum/internship by taking the Oath below.
- The Board may require additional information upon review.

**OATH**

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: \_\_\_\_\_

Who served as my Practicum/Internship Supervisor in the practice of Professional Counseling during the period of: \_\_\_\_\_ to \_\_\_\_\_  
 Month/Year Month/Year

and during that period he/she was licensed as a:  Professional Counselor  
 Clinical Social Worker  
 Marriage and Family Therapist  
 Psychologist  
 Psychiatrist  
 Certified Rehabilitation Counselor

License Number: \_\_\_\_\_ In the State of: \_\_\_\_\_

I have attached copies of letters and/or returned mail that demonstrates my attempt/s to reach this supervisor.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Applicant

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
 Notary Public  
 My Commission Expires: \_\_\_\_\_

NOTARY SEAL





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APPLICATION FOR ASSOCIATE PROFESSIONAL COUNSELOR  
PERSONAL REFERENCE FORM  
FORM D

**INSTRUCTIONS: NOFAXED FORMS ACCEPTED.**

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Professional Counseling.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.  
The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

**PART I – APPLICANT (Please print clearly)**

Name: \_\_\_\_\_

**PART II - REFERENCE**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: ( ) \_\_\_\_\_

Other Phone: ( ) \_\_\_\_\_

Relationship to Applicant:  Teacher  Supervisor

Dates of Teaching/Supervisory Relationship: FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:**

Title: \_\_\_\_\_

Agency/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

RECOMMENDATION: I  Recommend  Do Not Recommend the Applicant for licensure.

**ADDITIONAL COMMENTS;**

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date

Signature of Reference



**PART II – DIRECTED EXPERIENCE**  
**\*\*\*TO BE COMPLETED BY THE DIRECTOR\*\*\***

**INSTRUCTION:**

- The purpose of DIRECTION is to provide ongoing administrative oversight by an employer or superior in the practitioner's area of specialty.
- The Director is responsible for assuring the quality of the services provided and ensuring that qualified clinical supervision or intervention occurs in situations that require expertise beyond that of the employee.
- The Director must be located on-site and is specifically responsible for ensuring regularly-scheduled reviews of employee compliance with the Rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135) and all relevant federal, state, and local laws and regulations.
- **NOTE: Director and applicant (employee) must describe the content of the training experience and complete Part IV, Plan for Direction Section, on page 4.**

**DIRECTOR**

NAME: \_\_\_\_\_

TITLE/POSITION: \_\_\_\_\_

IF APPLICABLE:  LPC  LCSW  LMFT  Psychologist  Psychiatrist

Date License Issued: \_\_\_\_\_ Expires: \_\_\_\_\_ State: \_\_\_\_\_ Highest Earned Degree: \_\_\_\_\_

HOME TELEPHONE: ( ) \_\_\_\_\_

OFFICE TELEPHONE: ( ) \_\_\_\_\_

**EMPLOYMENT SITE**

NAME OF EMPLOYMENT SITE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

OTHER PROFESSIONAL STAFF AT EMPLOYMENT SITE (Attach a Separate Sheet, if Necessary):

1.	_____	_____	_____	_____
	Name	Degree	License (If Applicable)	Job Title
2.	_____	_____	_____	_____
	Name	Degree	License (If Applicable)	Job Title
3.	_____	_____	_____	_____
	Name	Degree	License (If Applicable)	Job Title
4.	_____	_____	_____	_____
	Name	Degree	License (If Applicable)	Job Title
5.	_____	_____	_____	_____
	Name	Degree	License (If Applicable)	Job Title

**AFFIDAVIT AND SIGNATURES**

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice under O.C.G.A. § 43-10A-7(9),(10), (11), (14), (15), (16) and (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

Signature of Applicant (Employee) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Director \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_

Day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public

My Commission Expires: \_\_\_\_\_

NOTARY SEAL

PART III – SUPERVISION

\*\*\*TO BE COMPLETED BY THE SUPERVISOR\*\*\*

INSTRUCTIONS:

- "SUPERVISION" is the direct clinical review, for the purposes of training or teaching, by a supervisor of interaction with a client/s in order to promote the development of clinical skills. It may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observation.
- The supervisor assumes complete clinical responsibility for all clients.
- The supervisor **does not** have to be located on-site.
- IMPORTANT: The requirements to be eligible to serve as a supervisor differ for Professional Counseling, Social Work and Marriage and Family Therapy. The number of hours and type (individual and/or group) of supervision is also specific to each license. See Chapter 135-5, Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Therapists for the precise requirements.
- NOTE: SUPERVISOR and APPLICANT (Employee) must complete PART V, Plan for Supervision, on page 4.

SUPERVISOR

NAME OF SUPERVISOR: \_\_\_\_\_

TITLE/POSITION:

IF APPLICABLE:  LPC  LCSW  LMFT  Psychologist  Psychiatrist

Date License Issued: \_\_\_\_\_ Expires: \_\_\_\_\_ State: \_\_\_\_\_ Highest Earned Degree: \_\_\_\_\_

HOME TELEPHONE: (\_\_\_\_) \_\_\_\_\_

OFFICE TELEPHONE: (\_\_\_\_) \_\_\_\_\_

SUPERVISOR'S EMPLOYMENT SITE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

City

State

Zip Code

Do you have any current or prior relationship with the applicant/employee?  No  Yes If "Yes," please explain: \_\_\_\_\_

MFT SUPERVISORS:

1. Do you intend to supervise this applicant for licensure as a Marriage and Family Therapist or Associate Marriage and Family Therapist?  Yes  NO

2. If "Yes," have you obtained one of the following required designations?

Board Approved MFT Supervisor  AAMFT Approved Supervisor

Supervisor's Name: \_\_\_\_\_

☞ See Board Rule 135-5-.06 for specific information.

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice under O.C.G.A. § 43-10A-7(9),(10), (11), (14), (15), (16) and (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

Signature of Applicant (Employee)

Printed Name

Date

Signature of Supervisor

Printed Name

Date

Subscribed and sworn before me this \_\_\_\_\_

Day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public

My Commission Expires: \_\_\_\_\_

NOTARY SEAL

PART IV – TRAINING EXPERIENCE AND PLAN FOR DIRECTION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe in detail below the content of the training experience and the specific plan for “Direction.”
- The plan must include, but is not limited to: 1) A description of the nature of the services being provided to the public; 2) the wages, salaries or other monetary considerations; and 3) a description of and declaration that both the direction and supervision occur on a regular basis.

PLAN FOR DIRECTION:

Signature of Director

Date

Signature of Applicant (Employee)

PART V – PLAN FOR SUPERVISION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe the specific “Supervision Plan” for this applicant (supervisee).
- “Supervision” means the direct, i.e., face-to-face, clinical review for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee’s interaction with a client/s. Supervision may include, but is not limited to, the review of case presentations, audio tapes, video tapes, and direct observations.
- **CONTRACT/AFFIDAVIT MUST SPECIFY THE NUMBER OF HOURS PER WEEK TO MEET THE 30 MINIMUM HOURS PER YEAR.**

PLAN FOR SUPERVISION:

Signature of Supervisor

Date

Signature of Applicant (Employee)

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