Reset Form

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 50710 (R11 / 8-24)

GENERAL INSTRUCTIONS: All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B****. You must submit proof that you have completed one thousand (1000) hours of post-graduate clinical experience, during which at least fifty percent (50%) of your clients were receiving marriage and family therapist services. This clinical experience must be obtained in no less than twenty-four (24) months. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. This form may be duplicated if your experience was completed at more than one place of employment. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name *(last, first, middle)*	Date of birth *(month, day, year)*

Employer's name of business	Employment Business Address *(number and street, city, state, and ZIP code)*
Name of direct supervisor	Direct supervisor title

I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date *(month, day, year)*

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: Complete this section.

Name of direct supervisor/employer *(last, first, middle)*

Name of business / institution where employed	Business E-mail address

Business address *(number and street, city, state, and ZIP code)*

Telephone number of business / institution ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)* *If currently employed, please indicate*

Average hours worked per week	Total clinical hours earned	Total relational hours earned

Provide a brief description of job duties:

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

Signature of direct supervisor/employer	Title
Printed Name of direct supervisor/employer	Date *(month, day, year)*

(Continued on the reverse side.)

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

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SECTION C / AFFIRMATION OF EXPERIENCE [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming experience received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

The applicant's director supervisor is unable to complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of employer

Name of business / institution where employed	E-mail address

Business address *(number and street, city, state, and ZIP code)*

Telephone number of business / institution ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)* *If currently employed, please indicate*

Position held	Number of hours of applicant worked per week

Total clinical hours	Total relational hours

Confirm direct service types provided at this location. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of job duties

I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct.

Signature of professional colleague	Date *(month, day, year)*

(Continued on the reverse side.)