

**TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL  
TEXAS STATE BOARD OF EXAMINERS OF  
MARRIAGE AND FAMILY THERAPISTS**



**SUPERVISED EXPERIENCE VERIFICATION FORM**

***A separate form is required to be completed by each board-approved supervisor.***

**I. Supervisee Information**

Name: \_\_\_\_\_ Associate License#: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

**II. Supervisor Information** (supervisor must meet the board’s criteria)

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Are you a Texas board-approved supervisor?  Yes  No

If no, submit official verification of licensure, including supervisor status if granted by other jurisdiction.

**III. Verification of supervision hours**

In the setting described below, I, the board-approved supervisor or supervisor from another jurisdiction, provided the following number of supervision hours to the named supervisee:

Verification of supervision hours:	HOURS
Hours of Individual Supervision	
Hours of Group Supervision	
<b>Total Hours:</b>	

Of the total supervision hours, how many were provided via telephonic or other electronic media? \_\_\_\_\_

**IV. Verification of supervised experience hours**

Include total number of supervised experience hours accrued by the LMFT Associate (not including the above-reported hours of supervision). The start date may be no earlier than the “Supervision Plan Approved” dated noted by board staff at the top of the Supervisor Agreement Form.

Dates: From \_\_\_\_\_ to \_\_\_\_\_ Total years and full months: \_\_\_\_\_

Of the total hours of professional services:	HOURS
How many hours were <i>direct clinical services</i> ?	
How many direct clinical hours were services to <i>couples or families</i> ?	
How many direct clinical hours were services to <i>individuals</i> ?	
How many hours were <i>indirect clinical services</i> ?	
<b>Total Practice Hours</b> (Direct + Indirect):	

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

**V. Affidavit of Accuracy and Signatures**

**Under penalties of perjury, I declare and affirm that the statements made in this Verification Form, including any accompanying statements or documents, are true, complete, and correct. I understand that giving the board false information of any kind may result in denial of licensure or other disciplinary action against the LMFT Associate and/or the LMFT Supervisor.**

\_\_\_\_\_  
Supervisee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

Mail To:  
**TX BHEC TSBEMFT**  
**333 Guadalupe 3-900**  
**Austin, TX 78701**