



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**VERIFICATION OF POST-DEGREE  
 SUPERVISED EXPERIENCE**

STATE COMMITTEE OF MARITAL AND FAMILY THERAPISTS  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 1335  
 JEFFERSON CITY, MO 65102  
 TELEPHONE (573) 751-0870  
 FAX (573) 751-0735  
 TDD (800) 735-2966

**INSTRUCTIONS** **PLEASE PRINT OR TYPE ONLY**

**APPLICANT:** Complete Section I Applicant Data only. Send or deliver the form to all supervisors whom you wish to have verify supervised experience in marital and family therapy. Please feel free to make copies of this form.

**SUPERVISOR:** Complete Sections II and III and return the form to:  
 STATE COMMITTEE OF MARITAL & FAMILY THERAPISTS  
 3605 MISSOURI BOULEVARD  
 POST OFFICE BOX 1335  
 JEFFERSON CITY MO 65102-1335.  
**Telephone (573) 751-0870 VOICE MAIL FAX (573) 751-0735 TDD (800) 735-2966 EMAIL maritalfam@pr.mo.gov**  
**DO NOT RETURN THIS FORM TO THE APPLICANT**

**I. APPLICANT DATA**

1. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN NAME)

2. ADDRESS (STREET AND BOX NO., IF APPLICABLE, CITY, STATE, ZIP)

**3. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION REQUESTED BELOW TO THE STATE COMMITTEE OF MARITAL AND FAMILY THERAPISTS.**

SIGNATURE OF APPLICANT ▶	SOCIAL SECURITY NUMBER	DATE
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**APPLICANT DO NOT WRITE BELOW THIS LINE — FOR SUPERVISOR'S COMPLETION ONLY**

**II. SUPERVISOR SECTION**

Complete items below and return the original (not a photocopy) of this application as soon as possible to State Committee of Marital and Family Therapists. **DO NOT RETURN THIS FORM TO THE APPLICANT.** You must verify all hours worked under your supervision.

4. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN) 5. TELEPHONE NUMBER (DAYTIME)

6. CURRENT OFFICE ADDRESS (STREET AND BOX NO., IF APPLICABLE, CITY, STATE, ZIP CODE)

**7. PLEASE CHECK ALL THAT APPLY TO SUPERVISOR. (PLEASE ATTACH A COPY OF APPLICABLE LICENSE.)**

	STATE LICENSED	LICENSE NUMBER
<input type="checkbox"/> LICENSED MARITAL AND FAMILY THERAPIST		
<input type="checkbox"/> LICENSED PROFESSIONAL COUNSELOR		
<input type="checkbox"/> LICENSED PSYCHOLOGIST		
<input type="checkbox"/> LICENSED PSYCHIATRIST		
<input type="checkbox"/> LICENSED CLINICAL SOCIAL WORKER		
<input type="checkbox"/> OTHER (Please indicate credential)		

**8. LIST SETTINGS WHERE THE APPLICANT PROVIDED MARITAL AND FAMILY THERAPY UNDER YOUR SUPERVISION**

A. AGENCY/FACILITY	ADDRESS (STREET, CITY, STATE, ZIP)	START DATE (MM/YYYY)	END DATE (MM/YYYY)
TOTAL HOURS OF PROVIDING MARITAL & FAMILY THERAPY RELATED DUTIES AND DIRECT CLIENT CONTACT ▶			
TOTAL HOURS OF DIRECT CLIENT CONTACT (SEE INSTRUCTIONS) ▶			
TOTAL HOURS OF INDIVIDUAL FACE TO FACE SUPERVISION (SEE INSTRUCTIONS) ▶			
B. AGENCY/FACILITY	ADDRESS (STREET, CITY, STATE, ZIP)	START DATE (MM/YYYY)	END DATE (MM/YYYY)
TOTAL HOURS OF PROVIDING MARITAL & FAMILY THERAPY RELATED DUTIES AND DIRECT CLIENT CONTACT ▶			
TOTAL HOURS OF DIRECT CLIENT CONTACT (SEE INSTRUCTIONS) ▶			
TOTAL HOURS OF INDIVIDUAL FACE TO FACE SUPERVISION (SEE INSTRUCTIONS) ▶			
C. AGENCY/FACILITY	ADDRESS (STREET, CITY, STATE, ZIP)	START DATE (MM/YYYY)	END DATE (MM/YYYY)
TOTAL HOURS OF PROVIDING MARITAL & FAMILY THERAPY RELATED DUTIES AND DIRECT CLIENT CONTACT ▶			
TOTAL HOURS OF DIRECT CLIENT CONTACT (SEE INSTRUCTIONS) ▶			
TOTAL HOURS OF INDIVIDUAL FACE TO FACE SUPERVISION (SEE INSTRUCTIONS) ▶			

