

Marriage and Family Therapist Form 4B

Certification of Supervised Experience

Applicant Instructions

Assigned Number (from Form 4): _____

1. Complete Section I. Be sure to sign and date item 9.
2. Send the entire form and a copy of Appendix A to the supervisor who will certify your experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

1. Last 4 Digits of Social Security Number _____
(Leave this blank if you do not have a U.S. Social Security Number)
2. Birth Date Month Day Year
3. Print Name Last
 First
 Middle
5. Telephone/Email Address
Daytime Phone
 Home or Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address Home or Business
(You must notify the Department within 30 days of any address or name changes)
Line 1 _____
Line 2 _____
Line 3 _____
City _____
State ZIP Code _____
Country/
Province _____
- Area Code Phone _____
Email Address (please print clearly)
 Home or Business _____
6. New York State DMV ID Number
(Driver or Non-Driver ID)

(Leave this blank if you do not have a New York State DMV ID Number)

7. Name as it appears on degree or other credentials (if different from above) _____

8. Name of supervisor _____ Assigned Number (from Form 4): _____

I practiced Marriage and Family Therapy as defined below:

"Marriage and family therapy is the assessment and treatment of nervous and mental disorders, whether affective, cognitive or behavioral, which results in dysfunctional interpersonal family relationships including, but not limited to familial relationships, marital/couple relationships, parent-child relationships, pre-marital and other personal relationships; and the use of mental health counseling, psychotherapy and therapeutic techniques to evaluate and treat marital, relational, and family systems, and individuals in relationship to these systems; and the use of mental health counseling and psychotherapeutic techniques to treat mental, emotional and behavioral disorders and ailments within the context of marital, relational and family systems to prevent and ameliorate dysfunction; and the use of assessment instruments and mental health counseling and psychotherapy to identify and evaluate dysfunctions and disorders for purposes of providing appropriate marriage and family therapy services."

Duration of supervised experience

Date beginning Date ending
 mo. day yr. mo. day yr.

Total client contact hours practicing Marriage and Family Therapy _____

9. I request and give my permission to the individual listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant Signature _____

Date _____

Section II: Certification of Supervised Experience

Instructions to the Supervisor: Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant. If the supervised experience occurred outside of New York State, you must include a copy of your license and an operating certificate or authorization for the entity to provide professional services.**

Name of the applicant _____
(see Section I, item 3)

I am a licensed _____ in _____
Professional title Jurisdiction

License number (attach a copy of your license if other than New York State) _____ Date licensed _____ mo. _____ day _____ yr.

I am attesting that I supervised the above named applicant for at least one hour per week or two hours every other week in the practice of marriage and family therapy (defined below):

"Marriage and family therapy is the assessment and treatment of nervous and mental disorders, whether affective, cognitive or behavioral, which results in dysfunctional interpersonal family relationships including, but not limited to familial relationships, marital/couple relationships, parent-child relationships, pre-marital and other personal relationships; and the use of mental health counseling, psychotherapy and therapeutic techniques to evaluate and treat marital, relational, and family systems, and individuals in relationship to these systems; and the use of mental health counseling and psychotherapeutic techniques to treat mental, emotional and behavioral disorders and ailments within the context of marital, relational and family systems to prevent and ameliorate dysfunction; and the use of assessment instruments and mental health counseling and psychotherapy to identify and evaluate dysfunctions and disorders for purposes of providing appropriate marriage and family therapy services."

Dates of experience From _____ To _____ Present
mo. day yr. mo. day yr.

Total hours practicing Marriage and Family Therapy _____

Identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ Marriage and Family Therapists.

Agency/Practice Name _____

Type of Setting (check one)

- Private practice owned by supervisor
- Professional entity (PLLC, PLLP, P.C.) owned by qualified qualified supervisor (attached consent from SED)
- Sole proprietorship or other entity authorized under law (attach certificate of corporation)
- Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), Department of Health (DOH), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)
- Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)
- Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)
- Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)
- Other (describe) _____

Agency/Practice address _____

Agency/Practice Phone _____ Fax _____ Email _____

Agency/Practice web site _____

The supervisor must be employed by the same agency as the applicant and have access to all patient files and records; have responsibility for the assessment, evaluation and treatment of each patient diagnosed and treated by the applicant practicing under his/her supervision; and each patient must consent to treatment by the supervised applicant.

Signature of agency representative _____ Date _____

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise a LMFT applicant. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Supervisor Signature _____ Date _____

Print Name _____

Address _____

Telephone _____ Fax _____ Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Marriage and Family Therapy Unit, 89 Washington Avenue, Albany, NY 12234-1000.