Verification of Supervision for Post-Graduate Mental Health Practice Hours

SUPERVISEE INFORMATION

To be completed by the supervisee.

Full Legal Name: ____
First *Middle* *Last*

Mailing Address: ____
Street/PO Box *City* *State/Zip*

License Number: ____________________ **License Type:** ____________________

SUPERVISOR INFORMATION

To be completed by the supervisor.

Full Legal Name: ____
First *Middle* *Last*

Mailing Address: ____
Street/PO Box *City* *State/Zip*

License Number: ____________________ **License Type:** __________ **Issue Date*** __________

**Proposed supervisors must have been actively engaged in licensed practice for at least 2 years before supervising post-graduate hours.*

For Supervisors of AMFT's: Please indicate which of the following you have completed in accordance with Utah Admin Code R156-60b-302d(3).

- ☐ Currently approved by AAMFT as an MFT supervisor.
- ☐ Successfully completed a supervision course in a COAMFTE accredited MFT program at an accredited university.
- ☐ Successfully completed 20 clock hours of instruction sponsored by AAMFT or the Utah Association for Marriage and Family Therapy.

For all license types:

☐ Yes ☐ No Is the supervisee a W-2 employee?

☐ Yes ☐ No Is the supervisor and supervisee working in the same place of employment?

If no, please provide a detailed explanation of how supervision is being conducted:

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Date Supervision contract was signed: ____

I certify I have read Utah Admin. Code R156-60-302. Supervised Training Requirements-Supervision Contract-Duties and Responsibilities of Supervisor and Supervisee. I understand that hours must be documented using the Division provided Post-Graduate Mental Health Supervised Hours form.

Signature of Supervisor: ______________________________ **Date:** ______________

Signature of Supervisee: ______________________________ **Date:** ______________