South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists
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P.O. Box 11329 • Columbia • SC 29211-1329
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www.llr.sc.gov/POL/Counselors/

PLAN OF SUPERVISION FOR CANDIDATE OF MFT SUPERVISOR LICENSURE

Candidate's Name_____

Preferred Address _____

_____

Daytime Telephone Number ( )_____

SC LMFT License #_____Expires _____

LMFT SUPERVISOR INFORMATION

Supervisor's Name _____

Professional Mailing Address:

Agency or Institution _____

Street/P.O. Box _____

City_____State_____Zip _____

Professional Telephone Number ( )_____

SC LMFT License #_____Expires _____

SC LMFT Supervisor License #_____Expires _____

PLAN FOR SUPERVISION

I plan to supervise the marriage and family therapy supervision of the above named candidate over a period of time to begin_____(month/year) and will end on approximately_____(month/year). During this period, we have agreed to meet_____times per week for approximately_____hours per meeting. I understand that, according to Board Regulations and policy, at least **36** contact hours must be in individual supervision of the candidate's supervision of at least two LMFT Associates (i.e., not more than two supervisors present during the supervisory sessions). At the completion of my supervision of this candidate, I will confirm completion of the supervision requirements by a log of hours and by letter from me and will provide a recommendation regarding his/her appropriateness for supervisory licensure.

_____ _____

Signature of LMFT Supervisor **Date**

CANDIDATE'S AFFIRMATION

"I HEREBY AFFIRM TO THE FACT THAT ALL INFORMATION PROVIDED BY ME AND OTHERS IS TRUE."

_____ _____

Signature of Candidate **Date**