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
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4658 • Contact.Counselor@llr.sc.gov • Fax: 803-896-4719
www.llr.sc.gov/POL/Counselors/

LMFT Confirmation of Clinical Supervision of Post-Master's Client Contact

REQUIRED

1. Please print or type. This blank form may be copied for distribution if you have more than one supervisor.
2. This form must be signed by the licensed supervisor and supervisor candidate (if applicable) and the signature of the applicant/LMFT associate. Original signatures are required.
3. Applicants who are required to be LMFT associates should return this completed form after the completion of the two year Associate licensure period. Mail to: **SC Board of Professional Counselors, P.O. Box 11329, Columbia, SC 29211-1329.**

Applicant Name (last, first, middle initial): _____

Social Security Number: _____

I have applied for licensure by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors, and Psycho-Educational Specialists. I am required to provide documentation of a minimum of 120 hours of supervision with a licensed professional LMFT supervisor or supervisor candidate of which a minimum of 100 hours are required to be individual supervision and 20 of these hours can be either group or individual supervision. Please complete the information below and return the form to me.

_____ _____
Applicant's Signature Date

INFORMATION BELOW TO BE COMPLETED BY SUPERVISOR (not applicant)

Licensed Supervisor or Supervisor Candidate Verification Information

Check appropriate category: ☐ Supervisor ☐ Supervisor candidate

Name (last, first, middle initial): _____

Preferred Mailing Address: _____

_____

City: _____ State: _____ ZIP Code (+4): _____

Daytime Telephone Number: _____

LMFT/S Name: _____
(if supervision was completed by a supervisor candidate, indicate the candidate's supervisor)

LMFT/S License Number: _____ LMFT/S License Expiration Date: _____

☐ *I verify that the applicant was under my supervision at which time I critiqued the applicant's counseling and counseling-related skills based on one or more of the following forms of observation of the supervisee's LMFT practice* (check all that apply):

☐ Direct/live observation ☐ Live supervision ☐ Audio recordings
☐ Written clinical materials ☐ Video recordings ☐ Co-therapy

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Applicant's Employment

Name, Address, Telephone and type of work experience (Minimum of two years of experience)	**Total Years**	**From** month/year	**To** month/year

1. Confirmation of Supervised Clinical Experience of Direct Counseling Client Contact
(must reflect a minimum of 1,380 hours of supervised clinical experience)

Confirmation of 1,380 hours of direct client contact with couples or groups under the supervision of an LMFT supervisor, supervisor candidate, or other qualified licensed mental health practitioner	**Total Hours**	**From** month/year	**To** month/year

2. Confirmation of 120 Hours of Post-Master's Immediate Supervision

Confirmation of hours of supervision by an LMFT supervisor or supervisor candidate (attach the supervision log)	**Total Hours**	**From** month/year	**To** month/year
A. Individual (a minimum of 100 hours required to be individual supervision)			
B. Group			

Recommendation:
I ☐ *recommend* ☐ *do not recommend this applicant for licensure as a South Carolina licensed professional marriage and family therapist.* (Note: If you do not recommend this applicant/Associate, the board requests that you send a separate letter directly to the board office stating your reasons.)

Additional Comments: _____

_____

_____

_____

Affidavit:
I attest that all information provided herein concerning supervision and work experience is accurate to the best of my knowledge and is in keeping with the Professional Counselors, Marriage and Family Therapists, Addiction Counselors, and Psycho-Educational Specialist's Practice Act. I understand that supervision for licensed Associates and the duration for associate licensure are for a period of not less than two (2) years.

Signature of Supervisor: _____ Date:_____
(Original signature required)

Signature of Supervisor Candidate (if applicable)_____ Date:_____
(Original signature required)