

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:

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:** _____