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08/17/10

**West Virginia Board of Examiners in Counseling  
815 Quarrier Street, Suite 212  
Charleston, West Virginia 25301  
1-800-520-3852**

**MFT SUPERVISOR'S VERIFICATION AND ASSESSMENT FORM**

**Applicant's Name:** \_\_\_\_\_ **Social Security:** XXX-XX-\_\_\_\_\_

The person listed above has applied to the West Virginia Board of Examiners in Counseling to become a Licensed Marriage & Family Therapist. As designated supervisor, your objective rating and verification are essential to determine whether this applicant meets the Board's standards. All applicants have the right to review their file.

**Supervisor's Name:** \_\_\_\_\_ **Profession:** \_\_\_\_\_

**License Number:** \_\_\_\_\_

**Business Name & Address:** \_\_\_\_\_

**Degree:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_

**Telephone:** (\_\_\_\_\_) \_\_\_\_\_

**Email:** \_\_\_\_\_

**Professional License :** \_\_\_\_\_ **State?** \_\_\_\_\_

**Out-of-State Supervisors must attach a copy of their most current license to this verification.**

Please rate the applicant compared to other counselors you know on the following characteristics. Place a check mark in every category.

<b>Characteristics</b>	<b>Out-standing</b>	<b>Above Average</b>	<b>Average</b>	<b>Below Average</b>	<b>Poor</b>	<b>Cannot Evaluate</b>
<b>Individual Therapy Skills</b>						
<b>Family/Couples Therapy Skills</b>						
<b>Group Therapy Skills</b>						
<b>Personal Integrity</b>						
<b>Consulting Skills</b>						
<b>Insight into client's problems</b>						
<b>Ability to relate to co-workers</b>						
<b>Ability to be objective on the job</b>						
<b>Ethical conduct</b>						
<b>Concern for welfare of clients</b>						
<b>Sense of responsibility</b>						
<b>Recognition of own limits</b>						
<b>Supervisory abilities</b>						
<b>Appropriate referral making</b>						
<b>Ability to keep material confidential</b>						

**Please complete both sides of this form**

I verify that this applicant for licensure as a Licensed Marriage & Family Therapist has spent

\_\_\_\_\_ AND \_\_\_\_\_  
(Total # of actual therapy/counseling activities hours) (Total # of actual hours spent with supervisor)

under my supervision in the following capacity:

\_\_\_\_\_ (Applicant's Position) \_\_\_\_\_ (Name of agency/institution)

I, certify, that the attached quarterly report and this supervisor's verification and assessment form is a true and accurate record of my supervision time with \_\_\_\_\_  
Name of Applicant

and I understand that providing misinformation to the Board may subject me to disciplinary action, including revocation of my license.

From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
(Date) (Date) (Supervisor's signature)  
(Dates must be filled in Month-Day-Year)

\_\_\_\_\_  
Print Name

Recommendation: I recommend this applicant for licensure as a Licensed Marriage & Family Therapist: [ ] Yes [ ] No

Briefly explain the nature of the supervision activities and types of clients served.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above information is based upon my best judgment. I am willing to answer additional questions concerning this evaluation if the Board deems it necessary.

\_\_\_\_\_  
(Signature of supervisor) (Date)

After completing this verification form, make a copy for your records, then enclose the completed form in a sealed envelope; **sign across the sealed flap**, and return the sealed envelope to the MFT applicant or mail directly to WVBEAC.