



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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**LMFT CONFIRMATION OF
 SUPERVISION HOURS FOR SUPERVISOR CANDIDATE**

Supervisor Candidate Name (as listed on license): _____

LMFT License Number: _____

**LMFT SUPERVISOR OR APPROVED QUALIFIED MENTAL HEALTH PRACTITIONER
 VERIFICATION INFORMATION**

(To be completed by supervisor candidate's supervisor)

Check appropriate category: LMFT Supervisor Qualified Mental Health Practitioner

License Type: _____ License No.: _____

Supervisor Name: (as shown on license) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone No.: _____ Email: _____

I verify that the supervisor applicant was under my supervision, at which time I critiqued the applicant's supervision of the following associate(s): (Supervisor Candidate must have supervised at least two but no more than six Associates over a period of not less than two years).

Associate Name: _____ Associate License No.: _____

Associate Name: _____ Associate License No.: _____

Associate Name: _____ Associate License No.: _____

Associate Name: _____ Associate License No.: _____

Associate Name: _____ Associate License No.: _____

Associate Name: _____ Associate License No.: _____

1. Documentation of Supervision of Supervision Candidate

(Must reflect a minimum of 36 hours of supervised supervision of candidate over a period of not less than two years.)

Date	Associate Name	Individual/Triadic Supervision Hours		Supervisor Signature or Initials
		Hrs.	mins.	
		Hrs.	mins.	
		Hrs.	mins.	
		Hrs.	mins.	
		Hrs.	mins.	
		Hrs.	mins.	

Total number of supervision hours: _____

2. Confirmation of Supervision of Supervision Candidate

	Total Hours	From (MM/YY)	To (MM/YY)
Confirmation of 36 hours of supervised supervision of at least two but no more than six Associates over a period of not less than two years.			

RECOMMENDATION

I recommend / I do not recommend this applicant for licensure as a South Carolina Marriage and Family Therapist Supervisor. **Note:** If you do not recommend this applicant, the board requests that you send a separate letter directly to the board office stating your reasons.

Additional comments:

ATTESTATION

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 Practice Act. I understand that the supervision period for Marriage and Family Therapy Supervisor candidates is for 36 hours over a period of not less than two years, and I attest that I provided the supervision required.

Signature of Supervisor: _____ Date: _____