Wisconsin Department of Safety and Professional Services

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MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

SUPERVISOR'S AFFIDAVIT OF APPLICANT'S COMPETENCIES - DOCUMENTATION OF CLINICAL EXPERIENCE GAINED UNDER TRAINING LICENSE

(A COPY OF THIS FORM IS TO BE COMPLETED BY EACH SUPERVISOR.)

Wis. Admin. Code ch. MPSW 12 requires an affidavit that the applicant, after receiving an appropriate Master's degree will complete at least 3,000 hours of supervised professional counseling practice, including at least 1,000 hours of face-to-face client contact. **Or**, the applicant will have completed, either during or after completion of a doctoral degree program, at least 1,000 hours of supervised professional counseling practice.

Consistent with Wis. Admin. Code ch. MPSW 12 and § 10.01(6), supervision requires one hour of face-to-face individual or group (**no more than 6 supervisees**) supervision to meet an average of one-hour per week duration during the supervised practice period. The supervisor may exercise discretion in averaging out supervision over the course of the period of supervision. The supervisor must meet the criteria under Wis. Admin. Code ch. MPSW 12.

APPLICANT: Complete this section and submit it to your supervisor. The form must be returned **directly from the supervisor** to the Department.			
Name of Applicant: (please print)			
Applicant's Training License Number:	-226	**Application Number:**	

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, please print and sign form.)	**Date**
	☐☐/☐☐/☐☐☐☐

SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Name of Supervisor: (please print)		
Supervisor's Licensure:	**Profession:**	**License Number:**

Dates the applicant was under my supervision:

From: ☐☐/☐☐/☐☐☐☐ **To:** ☐☐/☐☐/☐☐☐☐

I have supervised this applicant a total of _____ hours of supervised professional counseling experience, including _____ hours of face-to-face client contact. During this time, I met with the applicant for an average of one hour per week for face-to-face supervision as required per Wis. Admin Code ch. MPSW 12 and § 10.01(6).

Supervisor completion continued on next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion, continued.

Name of facility where applicant accumulated client-contact:			
Facility Address (number/street)	(city)	(state)	(zip code)
Brief description of applicant's clinical responsibilities in this position:			

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations. I swear that the foregoing information is true and accurate.

Signature of Supervisor: (If unable to provide a digital signature, print and sign form.)	**Date:**
	__/__/____
Title:	**Phone Number:**
	___-___-____