Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

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

MARRIAGE AND FAMILY THERAPIST SUPERVISED PRACTICE EXPERIENCE

(To be completed by supervisor following completion of supervised practice.)

APPLICANT: Complete this section and submit to your supervisor to verify your supervised practice. Form must be returned directly from the supervisor to the Department.

Last Name	First Name	MI	Former / Maiden Name(s)

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.)	Application Number	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.)

The applicant must complete at least 3,000 hours of Marriage and Family Therapy practice that includes at least 1,000 hours of face-to-face client contact. The person whose practice is being supervised shall receive a minimum of one hour of face-to-face supervision for each 10 hours of client contact. Practice of Marriage and Family Therapy which occurs as part of the requirements for obtaining a Master's or Doctorate degree in Marriage and Family Therapy or a substantially related field, shall not be considered to fulfill any part of the post-graduate supervised practice requirement.

Please identify your qualification(s) below:

- ☐ A licensed Marriage and Family Therapist with a Doctorate degree in Marriage and Family Therapy.
- ☐ A licensed Marriage and Family Therapist who has engaged in the equivalent of five (5) post-Master's degree years of full-time Marriage and Family Therapy.
- ☐ A Psychiatrist licensed under Wis. Stat. ch. 455.
- ☐ A Psychologist licensed under Wis. Stat. ch. 455.
- ☐ A person who holds an "**Approved Supervisor**" or "**Approved Supervisor In-Training**" certificate from American Association for Marriage and Family Therapy (AAMFT).
- ☐ An individual, other than an individual specified above, who was approved **in advance** by the Marriage and Family Therapist Section.

All supervisors shall be legally and ethically responsible for the activities of the Marriage and Family Therapist supervisee. Supervisors shall be available or make appropriate provision for emergency consultation and intervention. Supervisors shall be able to interrupt or stop the supervisee from practicing in given cases and to stop the supervised relationship if necessary.

Name of Agency:	
Supervisor's Name:	
Supervisor's Position Title:	
Supervisor's Credential Number:	

Supervisor completion continued on next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion, continued.

Dates of Supervised Experience:	From: ☐☐/☐☐/☐☐☐☐	To: ☐☐/☐☐/☐☐☐☐

I have supervised this applicant a total of _____ hours of MFT practice, including _____ hours of face-to-face client contact. The applicant shall receive a minimum of one hour of face to face supervision for every 10 client contact hours. If needed, make a copy of this form for each experience site.

I swear that the foregoing information is true and accurate and the candidate for licensure has met the requirements of Wis. Stat. § 457.10(3).

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.

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

Agency Address (number/street)	(city)	(state)	(zip code)

Daytime Phone Number	☐☐☐-☐☐☐-☐☐☐☐ **Ext** _____