MARYLAND
Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D.,M.P.H., Secretary

BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS
4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

CLINICAL SUPERVISION VERIFICATION

***To Applicant*: You must submit this form for each counseling experience (including internships/practicum) that you intend to apply toward the hours required for licensure. Make additional copies as needed.**

I hereby attest that, to the best of my knowledge, information, and belief,

_____ obtained _____ total hours of clinical experience under
Applicant's Name

my supervision from _____ to _____ at _____
(mo./yr.) *(mo./yr.)* *Name of Agency/Org.*

_____.
Address of Agency/Org.

Of the total number of hours listed above, _____ hours consisted of post masters, face to face* clinical supervision hours.

As the supervisor/employer of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of counseling?
□ Yes (please use additional sheets to explain) □ No

_____ _____
Name (printed) Lic. Type, Number and State of Issuance

_____ _____
Signature Date

Business Address: _____

Phone: _____ Email: _____

*"Face-to-face" means in the physical presence of the individuals involved in the supervisory relationship during wither individual or group supervision or using video conferencing which allows individuals to hear and see each other in actual points of time. It does not include telephone supervision; or internet communication that does not involve actual or real time video conferencing such as instant messaging services and social networking sites. COMAR 10.58.12.02