NORTH CAROLINA MARRIAGE AND FAMILY THERAPY LICENSURE BOARD

QUARTERLY SUPERVISION AND/OR NOTIFICATION OF SUPERVISION TERMINATION
Duplicate Form As Needed

Check one	Reporting Period	Not practicing, check below, initial & return.	Date Report Due
☐ 1st Quarter	1st Quarter - January 1 – March 31	☐ _____	April 30
☐ 2nd Quarter	2nd Quarter – April 1 – June 30	☐ _____	July 31
☐ 3rd Quarter	3rd Quarter – July 1 – September 30	☐ _____	October 31
☐ 4th Quarter	4th Quarter – October 1 – December 31	☐ _____	January 31

Instructions: Type or print the name of the supervisee and supervisor name and email where indicated. Send the form to supervisor (or refer him/her to where the form is found on the Board's website). The supervisor is to return the completed supervision form directly to the NC MFT Board in a sealed envelope with the supervisor's signature over the seal. It is suggested you ask the supervisor for a duplicate copy for your records. **Forms submitted without the supervisor's signature over the seal will not be accepted. Faxed copies are not accepted**. Supervisees may wish to provide a stamped, addressed envelope to the supervisor. If you did not practice during the reporting period, supervisees, please note in the checkbox above, initial the blank line and return the form to the NC MFT Licensure Board at the address below.

_____ _____
(Supervisee's name) *(Supervisor's name)*

_____ _____
(Supervisee's E-mail) *(Supervisor's E-mail)*

☐ **This is to certify that I, the above named supervisor, provided clinical supervision in accordance with the Supervision Agreement currently on file with the North Carolina Marriage and Family Therapy Licensure Board during the following period. My signature attests supervision was provided in accordance with section .0502 (b & c) of the NC Administrative Code. See www.nclmft.org (laws and rules) to review NC Statutes and Codes.**

Complete the following:
Period of Supervision From: _____ To:_____
(month, day, year) *(month, day, year)*
During the period of supervision listed above, the supervisee had _____hours of clinical practice *(both individual and group)* and I provided _____ hours of clinical supervision *(recommendation of* ***one*** *hour for every* ***seven and one half*** *hours of practice based on total requirement of 1500 clinical and 200 approved supervision requirement*. Minimum of one supervision hour per month required for LMFTAs). **NOTE: The Board may request additional documentation (tracking logs) to substantiate the reported hours.**

☐ Check here if supervisory arrangement has terminated and note last date of supervision:_____
Reason for termination – check all that apply:
☐Agreement completed – supervisor terminated arrangement
☐Applicant no longer making/keeping supervision appointments
☐Applicant indicated other supervisory arrangement has been made
☐Applicant has provided proof of MFT full licensure (LMFT status)
☐Other:_____

_____ _____
(Supervisor's signature) *(Date)*

RETURN FORM PER ABOVE INSTRUCTIONS *(sealed with signature of supervisor across the seal)*
TO: NC MFT Licensure Board,
Attn: Supervision Report, PO Box 5549, Cary, NC 27512