LMFT EVALUATION OF SUPERVISED EXPERIENCE

Name of Supervisee: _____

Board Approved Supervisor: _____

Is the Board Approved LMFT Supervisor also acting as the Board Approved On-site Supervisor? Yes: _____ No: _____

Name of Candidate's Employing Agency: _____

Was 100% of experience listed below accrued in accordance with 86:15-9-2(3)(A)(B)(C)(D)(E)? Yes: ____ _____ No: _____ _____

On a scale of 1-5, please provide the supervisor's rating of the supervisee's professional activity: _____

Work Week Beginning Date	Date(s) met with Supervisor	Dates of Observation (Live or Taped)	Date of Supervisor Consult w/ On-site	Total Face-to-Face Supervision Hours GRP	IND	Total Client-Contact Hours	Total Relational Hours
			TOTAL:				

CANDIDATE SIGNATURE: _____ **Date:** _____

SUPERVISOR(S) SIGNATURE(S): _____ **Date:** _____

Additional Signature(s):

If the candidate was supervised by more than one supervisor during this 6-month period, you may add as many signatures as required to page one of this evaluation form. You may also use to space below for any additional required signatures:

SUPERVISOR SIGNATURE:_____ **Date:** _____

SUPERVISOR SIGNATURE:_____ **Date:** _____

Supervision Rules and Regulations:

Please refer to Subchapter 9 of the Regulations to review all Supervised Experience Requirements. You may download the Regulations from the Board's website at www.ok.gov/behavioralhealth

Additional Supervisor comments (Optional):