New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Marriage and Family Therapy Examiners
124 Halsey Street, 6th Floor, P.O. Box 45007
Newark, New Jersey 07101
(973) 504-6415

☐ Approved
☐ Denied

By: _____

ASSOCIATE MARRIAGE AND FAMILY THERAPIST CLINICAL SUPERVISION PLAN
(This form should be completed by the Supervisor.)

Name of applicant:_____

Marriage and Family Therapy Associate License Number: _____

Supervisor Information

_____
Last name | First name | Middle initial | Other names if applicable

Business name: _____
Type of business (nonprofit, for profit, group, private, etc.)

_____
Business address

_____
City | State | ZIP code

Telephone number: _____ E-mail address:_____
(include area code)

ATTACH YOUR CURRENT RESUME/CIRRICULUM VITAE. IF YOU ARE LICENSED IN A STATE OR JURISDICTION OTHER THAN NEW JERSEY, CONTACT THE ISSUING LICENSING BOARD TO OBTAIN AN OFFICIAL LETTER OF GOOD STANDING.

Licensure of supervisor: (check all that apply)

☐ Marriage and Family Therapist ☐ Professional Counselor ☐ Psychologist ☐ Licensed Clinical Social Work
☐ Psychiatrist ☐ Family Physician ☐ Other _____

_____
Type of license or certificate | Number | State or jurisdiction issuing license or certificate | Date issued/expired

_____
Type of license or certificate | Number | State or jurisdiction issuing license or certificate | Date issued/expired

_____
Type of license or certificate | Number | State or jurisdiction issuing license or certificate | Date issued/expired

_____
Type of license or certificate | Number | State or jurisdiction issuing license or certificate | Date issued/expired

1. Have any of the supervisor's licenses ever been suspended, revoked or restricted? ☐ Yes ☐ No
   If "Yes," attach documentation and an explanation.

2. Where will client contact and supervision take place?

_____
Agency name | Address | Telephone number (include area code)

3. If you are not a licensed marriage and family therapist, what specific training do you have in marriage and family therapy?
_____ Date of training completion _____

4. What type of supervision did you receive? _____

5. What credentials did your supervisor(s) have? _____

6. Does the proposed supervisor have any other individuals under clinical supervision? ☐ Yes ☐ No
If "Yes," give the number of supervisees:_____
(N.J.A.C. 13:34-3.3 sets the limit at six (6) associate licensee supervisees.)

7. What is the proposed number of direct client contact hours you plan to meet WEEKLY?
Couples_____ Families_____ Individuals_____ Groups_____

8. What is the proposed number of hours of supervision you plan to meet WEEKLY?
Individual or Dyad (two people)_____ Group_____
N.J.A.C.13:34-2.3(b) requires a minimum of 50 hours of face-to-face supervision at a rate of one hour per week of which not more than 25 hours may be in group supervision.

9. What are the proposed hours of work-related activities each week? _____
N.J.A.C. 13:34-2.3(b) allows a maximum of 300 hours of other "work-related activities" that are defined to include preparing and maintaining client records as described in N.J.A.C. 13:34-8, report writing, maintaining appointment schedules, communicating with other professionals, preparing for supervision, preparing and maintaining financial records in accordance with N.J.A.C. 13:34-3.4 and 6.1, and any other activities deemed appropriate by the Board as set forth on the documentation of supervision forms.

10. What are the inclusive dates with the above supervisor? Beginning: _____ (month/day/year) Anticipated Ending: _____ (month/day/year)

11. Describe the proposed client services you are contracting to provide (please include the applicant's detailed job description):

_____
_____
_____
_____
_____
_____
_____
_____

12. Has the applicant read the N.J. statutes and regulations that accompany this application? ☐ Yes ☐ No
(N.J.S.A. 45:8B-1 et seq. and N.J.A.C. 13:34-1.1 though 13:34-9A.7)

13. Has the supervisor read the N.J. statutes and regulations that accompany this application? ☐ Yes ☐ No
(N.J.S.A. 45:8B-1 et seq. and N.J.A.C. 13:34-1.1 though 13:34-9A.7)

14. What are your personal learning objectives as you begin supervised client contact?

_____
_____
_____
_____

15. Will you have more than one supervisor in the above or another setting during the inclusive dates? ☐ Yes ☐ No
If "Yes," **complete another copy of the Associate Marriage and Family Therapist Clinical Supervision Plan** to provide the above-requested information regarding that supervisor.

_____ Applicant's signature
_____ Proposed supervisor's signature
_____ Date

Clinical References

Give the name and address of two professionally qualified individuals who know you well and who are in a position to evaluate your current clinical competence in marraige and family therapy.

_____

Name Address

_____

Name Address