KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky 40601
Phone (502) 564-3296 ~ http://mft.ky.gov

SUPERVISION PLAN FOR CLINICAL EXPERIENCE

(A separate Supervision Plan must be submitted for each Board Approved Supervisor)

Last Name | First Name | Middle Initial | Associate Permit #

Street Address | City | State | Zip Code

Email Address | Phone Number

PRIMARY CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Workplace Name | County of Practice | Phone Number

Street Address | City | State | Zip Code

Description of agency function (Check One)
☐ Hospital ☐ Mental Health Agency ☐ Private Practice ☐ Other ______________________

Beginning Date of Plan: ______________________ Estimated Ending Date: ______________________

ADDITIONAL CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Workplace Name | County of Practice | Phone Number

Street Address | City | State | Zip Code

Description of agency function (Check One)
☐ Hospital ☐ Mental Health Agency ☐ Private Practice ☐ Other ______________________

Beginning Date of Plan: ______________________ Estimated Ending Date: ______________________

BOARD APPROVED SUPERVISOR FOR THIS PLAN

Name | KY LMFT License #

Street Address | City | State | Zip Code

Home Phone Number | Work Phone Number

ASSOCIATE'S NAME: ____

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A. Provide a detailed description of the nature of this work setting, (must include clients to be seen, therapies and treatment modalities that shall be used including the prospective length of treatment, and problems or conditions that shall be treated).

B. Provide a detailed description of the nature, duration, and frequency of supervision in the practice, (must include number of hours of supervision per week, amount of group and individual supervision, and methodology for transmission of case information).

C. Provide a detailed description of the condition or procedures for termination of this relationship.

D. Provide hours per week spent in direct client-professional relationship (include assessment and treatment only).

***Pursuant to 201 KAR 32:035. Section 3.**

ASSOCIATE'S NAME: ____

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SUPERVISOR'S STATEMENT

I, the supervisor for the above named candidate for licensure for the independent practice of marriage and family therapy, have devised and discussed this plan with said applicant and accept responsibility for its implementation. Further, I understand that upon completion of the Supervision Plan for Clinical Experience and application for licensure as a Marriage and Family Therapist, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my license is current, and will be maintained throughout this period. I understand that I am accountable to the Board for the care given to the Marriage and Family Therapist Associate's clients.

Signature of Board Approved Supervisor: ______________________________ Date: ______________________

APPLICANT STATEMENT

I, the applicant in the above plan, understand that pursuant to 201 KAR 32:025, Section 2, I will be expected to comply with the provisions in this plan in its entirety and must notify the Board of any modifications of this plan once it has been approved. Failure to do so may result in voiding the approval given by the Board and loss of supervision hours gained.

Signature of Applicant: ____ Date: ______________________

ADMINISTRATIVE SUPERVISOR STATEMENT

If the supervision in the Supervision Plan for Clinical Experience in this application is provided by someone other than the applicant's agency supervisor, the agency supervisor must review the proposed plan and sign the statement below.

As agency supervisor of the above named candidate, I affirm the agency will support the proposed practice experience as described.

Signature of Agency Supervisor: _____________________________________ Date: ______________________

ASSOCIATE'S NAME: ____

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STATEMENT OF SHARED RESPONSIBILITY

If the supervision is to be received outside the applicant's place of employment, the section below must be completed and signed by the Board Approved Supervisor, the applicant, and an authorized person representing the agency.

We the undersigned, do hereby acknowledge the sharing of professional responsibility between

______________________________ and ______________________________
(Name of Agency) (Board Approved Supervisor)

for the clinical marriage and family therapy service provided to clients of the above named agency by

____
(Applicant)

and are jointly to be held accountable for the quality of the service provided. We further acknowledge that since the supervision outlined previously will take place outside the agency of employment and that the agency cases will be used in this supervisory relationship, complete and total confidentiality of client records will be maintained by all parties throughout the period.

____
Signature of Board Approved Supervisor License Number Date

____
Signature of Applicant Date

____
Signature of Agency Supervisor Job Title Date

ASSOCIATE'S NAME: ____