LMFT SUPERVISOR MENTOR CHECKLIST
FORM SUP 7

- □ Form MFT 1 - Completed General Information Form
- □ Form MFT 8 - Application for LMFT Supervisor Mentor
- □ $100.00 non refundable application and approval fee (Check or money order only, made payable to ABEMFT)

See application instructions for further details.
DO NOT SUBMIT AN INCOMPLETE APPLICATION
ALL INCOMPLETE APPLICATIONS WILL BE RETURNED

MFT 1
General Information Form

Alabama Board of Examiners in Marriage and Family Therapy
P.O. Box 240216
Montgomery, AL 36124-0216

Website: www.mft.alabama.gov

Application for:
- ☐ Supervisor Candidate
- ☐ Approved Supervisor
- ☐ Supervisor Mentor

Name:_____
Last First Middle/Maiden

Social Security Number:_____ **Gender:** ☐ Male ☐ Female

Date of Birth:_____ **Place of Birth**:_____

Are you a United States Citizen: ☐ Yes ☐ No

Have you ever held an Alabama Professional License Before? ☐ No ☐ Yes, as follow(s):

Name of Profession:_____ License #:_____

Name of Profession:_____ License #:_____

Name of Profession:_____ License #:_____

Work Mailing Address:

E-mail: _____

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Telephone:_____

Fax:_____

Home Mailing Address:

E-mail: _____

Street:_____

City:_____

State:_____ Zip:_____

County:_____

Telephone:_____

Fax:_____

Preferred Mailing Address (The address listed here will be public.):
☐ Work ☐ Home

APPLICATION FOR LMFT SUPERVISOR MENTOR
FORM SUP 8

Name:_____MFT License #:_____
Date designated LMFT Approved Supervisor:_____

SUPERVISOR EXPERIENCE:
List in reverse chronological order (most recent first) all places of professional employment experience in which you provided MFT supervision, indicating the number of supervisee hours of supervision along with your other responsibilities/activities. PLEASE SHOW MONTH AND YEAR FOR EACH. Use additional sheets if necessary.

1. Position:_____Phone:_____
   Organization:_____
   Address:_____
   Dates of Employment:_____to_____
   Contact Person:_____
   Primary Responsibilities/Activities:_____
   _____
   # of hours providing clinical services per week:_____
2. Position:_____Phone:_____
   Organization:_____
   Address:_____
   Dates of Employment:_____to_____
   Contact Person:_____
   Primary Responsibilities/Activities:_____
   _____
   # of hours providing clinical services per week:_____

SUPERVISON EXPERIENCE:
List names of MFT supervisees for whom you have provided the required 100 hours of MFT supervision beyond the required minimum of 180 hours of supervision to become an LMFT Approved Supervisor:

Name	Dates of Supervision	Hours of Supervision
	_____to_____	
	_____to_____	
	_____to_____	
	_____to_____	
	_____to_____	

Total: _____

I certify that the information on the reverse side is accurate, that I have provided a minimum of 280 hours of MFT supervision, and that I am qualified to provide MFT supervision of supervision to MFT supervisors in training in accordance with the ABEMFT Rules and Regulations. I further certify that I have read the responsibilities and guidelines for the provision of supervision.

_____ _____
Signature Date