verification of completion

Mail this completed verification to CAMFT. Be sure to enclose your check or charge to your credit card.
($75 if a CAMFT member, or $125 if a CAMFT non-member). Make check payable to CAMFT at address above.
This fee is non-refundable and covers the initial five-year certification.

Please indicate below any changes from the initial application:

Name: ____________________
(use name as it appears on initial application)

CAMFT Member Number: ____________ Non-Member: _____ (check here)

Preferred Mailing Address: ____________________

City, State, Zip: ____________________

Office Phone: ____________ Home Phone: ____________

Fax Number: ____________ E-Mail Address: ____________

1. Attach documentation to provide verification of completion of the required coursework.
2. Attach a log of the supervision experience that you have provided for purposes of this application. Supervision experience shall have been gained in no fewer than fifty-two weeks, with not less than one hour of individual or two hours of group supervision per week for each week in which supervision is provided.
3. Attach a log of the supervision consultation that you completed while supervising.
4. Attach the consultation summary. (One page)
5. Attach the written case summary. (3-5 pages)

Statements of Understanding—In order to qualify for the CAMFT Supervisor Certification:
I understand that CAMFT has the sole authority to grant, deny or revoke any supervisor certification issued, with or without cause.

- I agree to indemnify and release CAMFT, and any of its employees, directors, members, officers or agents from any and all liability that results from the services I render as a therapist, supervisor or consultant.
- I certify that all information contained in this application is true and correct. I certify that my license is current and in good standing.

____________________ ____________
Signature Date

I certify, as the supervision consultant, that the supervisor has been provided no less than twelve hours of supervision consultation with no less than one hour per month of individual, face-to-face consultation or no less than two hours per month of group consultation, for any month in which supervision was provided. ***I certify also that I have reviewed the supervisor's Written Case Summary, and that it is complete in its entirety, meeting all the required criteria.***

____________________ ____________
Name of Consultant (Please Print) Type of License & License Number

____________________ ____________
Signature of Consultant Date

Method of payment? (Circle one) Check MasterCard/Visa American Express

If paying by credit card, complete below: Amount: ________

Credit Card#: ____________ Exp. Date: ________ Card Security Code ________

Signature: ____________________

revised 10/15

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