Amend Mhp 302.01(c), effective 12-19-23 (Document #13786), cited and to read as follows:

Mhp 302.01 Pre-Licensure Supervised Practice.

(c) Prior to beginning supervised practice as required by RSA 330-A:22, all candidates for licensed supervised practice and each supervisor shall complete and submit the "Candidate for Licensure: Supervision Agreement" form ~~requiring the following~~ **and provide the following information**:

(1) The candidate for supervision to complete part I of the application ~~as follows~~**and provide the following information**:

a. Indicating which of the following types of supervision the candidate is applying for:

1. Pastoral psychotherapist;

2. **Licensed independent** ~~C~~ **c**linical social worker;

3. Clinical mental health counselor; ~~or~~

4. Marriage and family therapist;

5. School social worker;

6. Licensed social worker; or

7. Social work associate

b. The candidate's full legal name;

c. The candidate's home physical address;

d. The candidate's home mailing address if different from the physical address;

e. The candidate's home or cell phone number;

f. The candidates e-mail address;

g. The candidate's employer's name;

h. The candidate's employer's address;

i. The candidate's employer's phone number;

j. The candidate's title at their place of employment;

k. Supervisor's name at the place of employment;

l. **A** ~~L~~ **l**ist **of** the college(s) or university(s) attended **by the candidate**, the degree awarded, and date(s) of graduation;

m. ~~Answer~~**A** yes or no **answer** to the following questions and if applicable attach the requested document:

1. "Have you ever been denied a certification or license you applied for?" If yes attach a detailed description including the denying board(s), date of denial(s), and reason for denial(s);

2. "Have you ever been convicted of a felony or misdemeanor that has not been annulled?" If yes attach a detailed description of the offense(s) including the name of the court(s), date of conviction(s), and sentence(s) imposed; and

3. "Do you suffer from any emotional disturbance, mental illness, organic illness, or addictive disorder which presently impairs your ability to serve as a mental health practitioner?" If yes attach a detailed description of how your ability to practice is impaired;

n. ~~Answer~~ **A** yes or no **answer** to the question "Do you have a "Candidate for Licensure: Supervision Agreement" on file with the Board?; ~~and~~

o. ~~Answer~~**A** yes or no **answer to** the question "Are you changing supervisors?" If you answer yes attach a detailed explanation as to why you are changing supervisors; **and**

p. A yes or no answer to the question "Are you applying for conditional licensure?";

(2) The candidate's supervisor shall complete part II of the application **and provide the following information** ~~as follows~~:

a. The supervisor's full legal name;

b. The supervisor's employer's name;

c. The employer's address;

d. Employer's phone number;

e. Employer's e-mail address;

f. Supervisor's title at place of employment;

g. The physical address of where the supervision will take place;

h. ~~Answer~~ **A** yes or no **answer** to the question "Is the location where the supervision is to take place confidential?";

i. ~~Answer~~ **A** yes or no **answer** to the question "Does the candidate have a W-2 work relationship with the employer? ~~(Independent contractor relationship not permitted)"~~;

j. Check all that apply to "I hold a current, valid license in NH as:

~~i.~~ **(i)** Pastoral psychotherapist;

~~ii.~~ **(ii) Licensed independent** ~~C c~~linical social worker;

~~iii.~~ **(iii)** Clinical mental health counselor; ~~or~~

~~iv.~~ **(iv)** Marriage and family therapist";

(v) School social worker; or

(vi) Licensed social worker;

k. List license numbers;

l. **A** ~~Answer~~ yes or no **answer** to the question "Have you been licensed in New Hampshire for more than 2 years?"

m. **A** ~~Answer~~ yes or no **answer** to the following questions to ensure compliance with Mhp ~~302.01(c)(9)~~ **302.03(a)**:

1. Did the supervisor complete a "graduate level course in clinical supervision?";

2. Was the "clinical supervision approved by one of the following?

~~i.~~ **(i)** Association for ~~c~~ **C**linical ~~p~~ **P**astoral ~~e~~ **E**ducation;

~~ii.~~ **(ii)** National Association of Social Workers;

~~iii.~~ **(iii)** American Mental Health Counselors Association; or

i~~v.~~ **(iv)** American Association for Marriage and Family Therapy"; and

3. **A yes or no answer to the question** "Does the supervisor have ~~twelve~~ **12** continuing education units (CEU's) in clinical supervision through participation in a seminar or workshop was approved by a Category A sponsor listed in Mhp 402.02(a)(1).";

n. Attach documentation proving the yes answer checked in response to ~~n~~. **m.** above;

o. **A** ~~Answer~~ yes or no **answer** to the question "Are you an employee of your supervisee's clinical site?";

p. If you answer no to ~~p.~~ **o.** above attach a detailed statement which addresses the following:

1. **"**Your relationship to the candidate's employer or clinical site**"**;

2. **"**Acknowledging that you will provide supervision at the candidate's place of employment or the clinical site where the applicant delivers services, at a mutually convenient and ethically appropriate site, or using a virtual HIPAA compliant platform**"**;

3. **"**That you have knowledge of candidate's employer's policies**"**; and

4. **"**How any disagreements between the contracted supervisor and the agency supervisor will be resolved**"**;

q. Attach a copy of the written agreement with the candidate's employer that allows you to review records, files, and any other documentation at the supervisee's place of employment or clinical site. This agreement shall be signed and bear the date of the signature; and

r. Certify the following statement by signing and dating the application:

"I affirm that I have reviewed the candidate's education record and it conforms with those outlined in Mhp 303, Mhp 304, Mhp 305, ~~or~~ Mhp 306, **Mhp 307, or Mhp 308** whichever refers to the appropriate candidate license type.

Additionally, I have read and shall conform to the laws of New Hampshire and the Board of Mental Health Practice Administrative Rules Mhp 100-500."

(3) ~~Under p~~ Part III of the application ~~the following~~ shall be completed **by the supervisor and the candidate and shall provide the following information**:

a. Answer the question "What is the frequency of individual supervision? ~~(~~ One hour of supervision is 60 minutes~~)~~**.**";

b. Answer the question "What is the length of individual supervision?"; **and**

c. The candidate and supervisor shall complete and attach a description of the goals of supervision**,** that **is signed and dated by the candidate and the supervisor**, ~~that~~ **and** include**s** at least the following:

1. Ethics;

2. Diagnosis and assessment;

3. Theoretical applications;

4. Community resources;

5. Specific competence; and

6. Cross cultural issues; and

(4) Under part IV of the application the following shall be ~~competed.~~ **completed as described below:**

a. A candidate for licensure under this agreement shall certify by signing and dating the application under the preprinted statement:

"As a Candidate, I agree to provide my supervisor with all pertinent information concerning all clients and their care in order to make informed, ethical, and

efficacious decisions for client care. I will inform my supervisor if I engage in any clinical activities outside of this agreement. I understand that all my clinical activity must be authorized by my supervisor. I will resolve all ethical dilemmas and practice issues as directed by my supervisor to the best of my ability. This supervision agreement does not remove any legal or civil responsibilities that I have for my actions related to this role.";

b. The supervisor shall certify by signing and dating the application under the following statement:

"As the Supervisor, I agree to provide my Candidate with appropriate and efficacious training, guidance, and direction to assure a valuable training experience to meet standards for the Candidate's licensure. I acknowledge that, at a minimum, under RSA 330-A:22, I will hold ~~weekly~~ **consistent**, one-hour face-to-face meetings at the site where the Candidate works, I will assume professional and legal responsibility for the Candidate, and I will review and have access to the Candidate's clinical records. If I cease to supervise the Candidate, if my license becomes invalid, restricted, or sanctioned in NH or any other jurisdiction, or if I wish to terminate my legal and professional responsibility for the Candidate's acts or omissions, I am responsible to notify the Board and the Candidate in writing, and that until I do, I remain responsible.";

c. In addition to b. above the supervisor of a marriage and family therapist shall certify by signing and dating the application a second time under the following statement:

"I acknowledge that, at a minimum, under RSA 330-A:22, I will hold ~~weekly~~, **consistent** one-hour face-to-face meetings and that I will assume professional and legal responsibility for the Candidate. I will review and have access to the Candidate's clinical records. When providing outside Marriage and Family group supervision under Mhp 303.17 (e)(3), I will hold group face-to-face meetings with no more than six Candidates."; and

d. All candidates and supervisors shall sign and date the application, in addition to any other signatures already affected to the application, certifying the following statement:

"All statements and information contained in this form are true and correct to the best of my knowledge and belief. I acknowledge that the provision of false information on this form is a basis for denial of this application."

Amend Mhp 302.05(b)(1), (b)(2)a., (b)(3), and (b)(4), effective 12-19-23 (Document #13786), cited and to read as follows:

Mhp 302.05 Licensure Application Process.

(b) Each applicant for licensure shall submit with the application the following **information and** supporting documentation:

(1) One of the following supervised clinical experience forms:

a. The "Summary of Supervised Clinical Experience Form – Clinical Mental Health Counselor**s**, **Licensed** Independent Clinical Social Workers, **Licensed Social Workers,**

Social Work Associates, Pastoral Psychotherapist**s**, or School Social Workers" requiring the following information:

1. Applicant's name;

2. Start and end date of each ~~post-graduate~~ supervised clinical experience;

3. Name of facility for each supervised clinical experience;

4. Name of supervisor for each supervised clinical experience;

5. Total hours of each individual supervision received for each supervised clinical experience;

6. Total hours of clinical experiences for each supervised experience;

7. Total hours of supervised clinical experience for all experiences; and

8. The applicant's signature and date of signing below the following attestation:

"By signing below, I certify that the foregoing is correct to the best of my knowledge."; or

b. The "Summary of Supervised Clinical Experience Form – Marriage and Family Therapist" requiring the following information:

1. Applicant's name;

2. Start and end date of each supervised clinical experience;

3. Name of facility for each supervised clinical experience;

4. Name of supervisor for each supervised clinical experience;

5. Total hours of each individual supervision received for each supervised clinical experience;

6. Total hours of client contact for each supervised clinical experience;

7. Total hours of clinical experiences for each supervised experience;

8. Total hours of supervised clinical experience for all experiences; and

9. The applicant's signature and date of signing below the following attestation:

"By signing below, I certify that the foregoing is correct to the best of my knowledge.";

(2) One of the following supervisor's confirmation of clinical experience forms:

a. The "Supervisor's Confirmation of Clinical Experience Form – Clinical Mental Health Counselors, **Licensed** Independent Clinical Social Workers, **Licensed Social Workers, Social Work Associates,** ~~and~~ Pastoral Psychotherapists, or School Social Workers" requiring the following information:

1. The applicant's name, address including city, state, and zip code, signature, and date of signing under the following statement:

"I am applying for licensure as a clinical mental health counselor, **licensed** independent clinical social worker, pastoral psychotherapist, ~~or~~ **school social worker, licensed social worker or social work associate** in the State of New Hampshire. The Board of Mental Health Practice requires confirmation of supervised clinical experience. This is your authority to release all information you have in your files."

2. Name of facility where the ~~post-masters~~ supervised clinical experience took place;

3. Address of facility where the ~~post-masters~~ supervised clinical experience took place;

4. Applicant's title at the time of supervision;

5. Beginning and ending month and year of supervised clinical experience;

6. Hours per week of face-to-face individual supervision;

7. Total hours of face-to-face supervision;

8. Total hours of paid ~~post-master's~~ supervised clinical work experience, which is the number of hours worked per week times the number of weeks worked;

9. ~~Answer~~ **A** yes or no~~t~~ **answer** to the question "If the supervision took place in New Hampshire was an approved "Candidate Licensure supervisor Agreement" on file ~~in the board's office~~ **with the board** prior to the commencement of supervision?"

10. Attach to this form a description of the supervisor**y** methods and the types of issues ~~delt~~ **dealt** with during supervision, a description of the type of work performed by the applicant, and a description of the quality of work performed by the applicant completed by the supervisor;

11. Printed name of supervisor(s);

12. Title of supervisor at the time of supervision;

13. Supervisor's business address;

14. Highest degree earned by the supervisor;

15. ~~What is the supervisor licensed as~~ **The supervisor's license type,** ~~including the~~ state of licensure, license number, and date the license was issued;

16. Supervisor's phone number; and

17. Supervisor's signature and date of signing; or

(3) Three separate and distinct "Professional Reference Forms", each signed by the person providing the reference, at least one of which ~~is~~ **shall be** from a supervisor.

(4) ~~The~~**A completed** "Professional Reference Form" ~~shall be provided by the board and require~~ **with** the following information **as specified below**:

a. The applicant for initial licensure shall complete the following information on the form before providing the form to the professional reference:

1. A check mark next to the type of application being applied for, **licensed** independent clinical social worker, clinical mental health counselor, marriage and family therapist, ~~or~~ pastoral psychotherapist**, school social worker, licensed social worker, social work associate**;

2. Their full legal name;

3. Their physical address including city, state, and zip code; and

4. Their signature and date of signing; and

b. ~~After the applicant for licensure has completed the portion of the form described in a. above the applicant shall have the~~ **Each** professional reference **shall** provide the following information on the form:

1. Their full legal name;

2. Their relationship with the applicant;

3. The length of time they have known the applicant;

4. A brief description of their knowledge of the applicant's professional and ethical behavior;

5. The name of the organization and the applicant's title and position at the organization when the professional reference worked with the applicant;

6. A brief description of the applicant's duties and responsibilities ~~at the organization described in v. above~~;

7. The area of the applicant's specialties;

8. A brief description of any knowledge that the applicant:

a. Has been or is the subject of any malpractice or civil suit involving the practice of their profession;

b. Has been charged or convicted of a crime in any state or country, the disposition of which was other than acquittal or dismissal;

c. Has been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence, or negligence made or pending against them;

d. Has ever been required to surrender their license or certification; or

c. Has been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or county by any licensing board or professional ethics body;

9. An attestation and certification that the reference believes that the applicant is an individual of good professional and moral character, and if the answer is no to provide an explanation;

10. A check mark next to the type of endorsement: without reservation, with reservation, or not recommended;

11. If the reference indicates with reservation or not recommended then provide a written explanation of that answer;

12. Their mailing address, phone number, title, degree, license or certification specialty, state(s) in which they are licensed, and license number(s); and

13. Signature and date of signing; and

c. The professional reference shall provide the "Professional Reference Form" to the applicant in a sealed envelope signed so it is evident it has not been tampered with.

APPENDIX I

Rule	**Specific State Statute the Rule Implements**
Mhp 302.01(c)	RSA 330-A:22; RSA 330-A:18-b, III; RSA 330-A:18-c, III; RSA 330-A:18-d
Mhp 302.05(b)(1), (b)(2)a.,(b)(3), and (b)(4)	RSA 330-A:10

Readopt with amendment the form "Candidate for Licensure: Supervision Agreement" (Revised 7/2023), whose requirements are set forth in Mhp 302.01(c), effective 12-19-23 (Document #13786), to read as follow:

BOARD OF MENTAL HEALTH PRACTICE

CANDIDATE FOR LICENSURE: SUPERVISION AGREEMENT

PART I - TO BE COMPLETED BY THE CANDIDATE

CIRCLE ONE: I am a candidate for licensure for:

- PASTORAL PSYCHOTHERAPIST
- **LICENSED** INDEPENDENT CLINICAL SOCIAL WORKER
- CLINICAL MENTAL HEALTH COUNSELOR
- MARRIAGE AND FAMILY THERAPIST
- **SCHOOL SOCIAL WORKER**
- **LICENSED SOCIAL WORKER**
- **SOCIAL WORK ASSOCIATE**

Signatures placed on this form authorize the release of information directly to the New Hampshire Board of Mental Health Practice through the Office of Professional Licensure and Certification.

Candidate's Full Legal Name: _____

Home Physical Address: _____
Street

_____
City State Zip

Home Mailing Address if Different from Physical Address: _____

_____

E-mail address: _____ Home or Cell Phone Number: _____

Name of Employer: _____

Employer's Address: _____
Street

_____
City State Zip

Business Phone Number: _____ Title at place of employment: _____

Supervisor's name at place of employment: _____

College/University Degree Awarded Date **of Graduation** ~~Awarded~~

_____

_____

	Yes	No
Have you ever been denied a certificate or license you applied for and if so, the name of the denying board, the date of the denial, and the reasons for denial?		
Have you ever been convicted of a felony or misdemeanor that has not been annulled? If "Yes" on a separate sheet provide, the name of the court, the details of the offense, the date of the conviction, and sentence imposed.		
Do you suffer from an emotional disturbance, mental illness, organic illness, or addictive disorder which presently impairs your ability to serve as a mental health practitioner?		

Are you changing supervisors? Yes No
If you answer yes attach a detailed explanation of why you are changing supervisors.

Do you have a "Candidate for Licensure Supervision Agreement" on file with the Board? Yes No

Are you applying for conditional licensure? Yes No

PART II - TO BE COMPLETED BY SUPERVISOR

Supervisor's Full Legal Name: _____

Employers Name: _____

Employer's Address: _____
Street

_____
City State Zip

Employers Phone #: _____ Employers Email address: _____

Title at Place of Employment: _____

Address of the location where the supervision shall take place: _____

_____
Street

_____
City State Zip

Is the location of where the supervision to take place confidential? Yes No

~~All candidates must have a W-2 work relationship with employer.~~ ~~Do you have this type of relationship ? (Independent contractor relationship not permitted)~~

Does the candidate have a W-2 work relationship with the employer? Yes No

I hold a current, valid license in NH as: (Check all that apply)

[ ] Pastoral Psychotherapist [ ] **Licensed Independent** Clinical Social Worker
[ ] Clinical Mental Health Counselor [ ] Marriage and Family Therapist
[ ] School Social Worker **[ ] Licensed Social Worker**

License number(s): _____

Have you been licensed in NH for more than two years? Yes No

Mhp ~~302.01 (c)(9)~~ **302.03(a)**, requires supervisors to have successfully completed one of the following. Indicate "Yes" or "No" to questions 1 – 3 and attach documentation that shows proof of completion.

1. Graduate level course in clinical supervision? Yes No

2. **Was the** ~~C~~ **c**linical supervision approved by one of the following? Yes No
   a. Association for Clinical Pastoral Education;
   b. National Association of Social Workers;
   c. American Mental Health Counselors Association; or
   d. American Association for Marriage and Family Therapy

3. **Does the supervisor have** ~~Twelve~~ **12** continuing education units (CEUs) in clinical supervision through participation in a seminar or workshop approved by a Category A sponsor listed in Mhp 402.02 (a)(1). Yes No

Are you an employee of your supervisee's clinical site? Yes No

If you answered "no" to this question attach a written statement which addresses the following:

1. Your relationship to the candidate's employer ~~/~~ **or** clinical site.
2. Acknowledging that you will provide supervision at the candidate's place of employment ~~/~~**or the** clinical site where the applicant delivers services, at a mutually convenient and ethically appropriate site, or using a virtual HIPAA compliant platform.
3. That you have knowledge of candidate's employer's policies.
4. How any disagreements between the contracted supervisor and the agency supervisor will be resolved.
5. The above submitted statement shall include a copy of a written agreement with the candidate's employer that allows you to review records, files, etc. at the supervisee's place of employment ~~/~~**or** clinical site. This agreement must be signed and bear the date of the signature.

I affirm that I have reviewed the candidate's education record and it conforms with those outlined in Mhp 303, Mhp 304, Mhp 305, ~~or~~ Mhp 306, **Mhp 307, or Mhp 308** whichever refers to the appropriate candidate license type.

Additionally, I have read and am prepared to conform to the laws of New Hampshire and the Board of Mental Health Practice Administrative Rules Mhp 100-500.

_____ _____
Supervisors Signature Date

PART III - SUPERVISION INFORMATION – To be completed by supervisor and candidate

What is the ~~F~~ frequency of individual supervision**?~~:~~,** _____
~~(~~One hour of supervision is 60 minutes~~)~~

What is the ~~L~~ length of individual supervision?~~:~~

_____

Attach on a separate page a description of the goals of supervision.
Goals are the responsibility of the supervisor and the candidate. When describing goals, you shall include, but not be limited to, the following: ethics, diagnosis and assessment, theoretical applications, community resources, specific competence, and cross-cultural issues.

*****Goals statement must be signed and dated by the Candidate and the Supervisor**

PART IV - ATTESTATIONS – READ STATEMENT BELOW CAREFULLY

ALL CANDIDATES

As Candidate, I agree to provide my supervisor with all pertinent information concerning all clients and their care in order to make informed, ethical, and efficacious decisions for client care. I will inform my supervisor if I engage in any clinical activities outside of this agreement. I understand that all my clinical activity must be authorized by my supervisor. I will resolve all ethical dilemmas and practice issues as directed by my supervisor to the best of my ability. This supervision agreement does not remove any legal or civil responsibilities that I have for my actions related to this role.

_____
Candidate's Signature Date

SUPERVISOR

As the Supervisor, I agree to provide my Candidate with appropriate and efficacious training, guidance, and direction to assure a valuable training experience to meet standards for the Candidate's licensure. I acknowledge that, at a minimum, under RSA 330-A:22, I will hold ~~weekly~~ **consistent**, one-hour face-to-face meetings at the site where the Candidate works, I will assume professional and legal responsibility for the Candidate, and I will review and have access to the Candidate's clinical records. If I cease to supervise the Candidate, if my license becomes invalid, restricted, or sanctioned in NH or any other jurisdiction, or if I wish to terminate my legal and professional responsibility for the Candidate's acts or omissions, I am responsible to notify the Board and the Candidate in writing, and that until I do, I remain responsible.

_____
Supervisor's Signature Date

IN ADDITION TO THE STATEMENT TO BE SINGED BY THE SUPERVISOR ABOVE THE SUPERVISOR OF A MARRIAGE AND FAMILY THERAPISTS SHALL DATE AND SIGN BELOW THE FOLLOWING

I acknowledge that, at a minimum, under RSA 330-A:22, I will hold ~~weekly~~ **consistent**, one-hour face-to-face meetings and that I will assume professional and legal responsibility for the Candidate. I will review and have access to the Candidate's clinical records. When providing outside Marriage and Family group supervision under Mhp ~~303.17 (e)(3)~~ **306.020(f)**, I will hold group face-to-face meetings with no more than six Candidates.

_____
Supervisor's Signature & Date

FOR ALL CANDIDATES AND SUPERVISORS TO READ AND SIGN

All statements and information contained in this form are true and correct to the best of my knowledge and belief. I acknowledge that the provision of false information on this form is a basis for denial of this application.

Signature of Candidate: _____ Date: _____

Signature of Supervisor: _____ Date: _____

When the board approves the agreement a copy will be sent to the candidate.

BOARD APPROVAL:

_____

Board Member Date

EFFECTIVE DATE OF COMMENCEMENT OF SUPERVISION _____

Mhp 302.01 (n) states "Pursuant to RSA 330-A:22, IV, no hours of supervised practice shall be credited to the candidate until the "Candidate for Licensure Supervision Agreement" has been approved by the Board."

Readopt with amendment the "Supervisor's Confirmation of Clinical Experience Form - Clinical Mental Health Counselors, Independent Clinical Social Workers, Pastoral Psychotherapist, or School Social Workers" (Revised 7/2023), whose requirements are set forth in Mhp 305.05(b)(2)a., effective 12-19-23 (Document #13786), to read as follows:

BOARD OF MENTAL HEALTH PRACTICE

SUPERVISOR'S CONFIRMATION OF CLINICAL EXPERIENCE FORM - CLINICAL MENTAL HEALTH COUNSELORS, **LICENSED** INDEPENDENT CLINICAL SOCIAL WORKERS, PASTORAL PSYCHOTHERAPIST**S**, **LICENSED SOCIAL WORKER**S, **SOCIAL WORK ASSOCIATES** OR SCHOOL SOCIAL WORKERS

This request to the Supervisor for release of information to the Board is to be completed by the applicant and forwarded to the supervisor of clinical experience.

Send one form to each supervisor and have them return it to you in a signed sealed envelope.

I am applying for licensure as a CLINICAL MENTAL HEALTH COUNSELOR, **LICENSED** INDEPENDENT CLINICAL SOCIAL WORKER, PASTORAL PSYCHOTHERAPIST, **LICENSED SOCIAL WORKER**, **SOCIAL WORK ASSOCIATE** OR SCHOOL SOCIAL WORKER in the State of New Hampshire. The Board of Mental Health Practice requires confirmation of supervised clinical experience. This is your authority to release all information you have in your files.

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

SUMMARY OF ~~POST-MASTERS~~ SUPERVISED CLINICAL EXPERIENCE

Name of Facility: _____

Address of Facility: _____

Applicant's Title at the time of supervision: _____

Dates of Supervised Clinical Experience: From (Mo/Yr) _____ to (Mo/Yr) _____

FACE-TO-FACE Individual Supervision: Hrs per Wk: _____ Total supervised face-to-face hours: _____

Total Hours of Paid ~~Post-Master's~~ Supervised Clinical Work Experience*: _____
(* Number of hours worked per week X Number of weeks worked)

If the supervision took place in New Hampshire was an approved "Candidate Licensure Supervisor Agreement" on file~~ in the Board's Office~~ **with the board** prior to the ~~C~~ **c**ommencement of supervision? [ ] Yes [ ] NO

SUPERVISOR'S CONFIRMATION

Supervisor: Provide on a separate sheet attached to this form:

1) A description of the supervisory methods and the types of issues dealt with during supervision;
2) A description of the type of work performed by the applicant; and
3) A description of the quality of work performed by the applicant.

Printed Supervisors Name: _____

Supervisor's Title at the time of Supervision:
_____

Supervisor's Business Address:
_____

Highest degree earned **by the Supervisor**: _____

~~Licensed as~~ **Supervisor's License Type**: _____ State: _____ License#: _____ Date Issued: _____

Supervisor's Phone Number: _____

Supervisor's Signature: _____ Date: _____

Readopt with amendment the "Summary of Supervised Clinical Experience Form – Clinical Mental Health Counselors, Independent Clinical Social Workers, Pastoral Psychotherapist or School Social Workers" (Revised 3/2023), whose requirements are set forth in Mhp 302.05(b)(1)a, effective 12-19-23 (Document #13786), to read as follows:

BOARD OF MENTAL HEALTH PRACTICE

SUMMARY OF SUPERVISED CLINICAL EXPERIENCE FORM –
CLINICAL MENTAL HEALTH COUNSELORS, **LICENSED** INDEPENDENT CLINICAL SOCIAL WORKERS, **LICENSED SOCIAL WORKERS, SOCIAL WORK ASSOCIATES,** PASTORAL PSYCHOTHERAPISTS, OR SCHOOL SOCIAL WORKERS

All applicants are required to complete the "Summary of Supervised Clinical Experience" form and submit it with the application. The hours on this form must match the hours verified on the supervisor's confirmation of clinical experience form. This includes both present and if applicable past supervisors.

APPLICANT'S NAME: _____

Start & end date of ~~post-grad supervision~~ **supervised clinical experience**	Name of Facility **for Each Supervised Clinical Experience**	Name of Supervisor **for Each Supervised Clinical Experience**	Total Hours of **Each** Individual Supervision **Received for Each Supervised Clinical Experience**	Total Hours of **Supervised** Clinical Experience **for all Experiences**
Total Hours of Supervised Clinical Experience **for all Experiences**				

BY SIGNING BELOW, I CERTIFY THAT THE FOREGOING IS CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE _____ DATE _____

Readopt with amendment the "Professional Reference Form" (Revised 7/2023), whose requirements are set forth in Mhp 302.05(b)(4), effective 12-19-23 (Document #13786), to read as follow:

BOARD OF MENTAL HEALTH PRACTICE

PROFESSIONAL REFERENCE FORM

To be completed by applicant and forwarded to the reference:

I am applying for (check one that applies):

[ ] **Licensed** Independent Clinical Social Worker
[ ] Marriage and Family Therapist
[ ] School Social Worker
[ ] Social Work Associate
[ ] Clinical Mental Health Counselor
[ ] Pastoral Psychotherapist
[ ] Licensed Social Worker

The applicant's signature on this form authorizes the reference to release information to the NH Board of Mental Health. All parts must be completed legibly in ink.

Applicant's Full Legal Name: _____

Applicant's Physical Address: _____
Address City State Zip Code

Applicant's Signature: _____ Date of Signature: _____

TO BE COMPLETED BY REFERENCE:

Professional Reference's Full Legal Name: _____

Professional relation to applicant: _____

Length of time you've known applicant: From (Mo/Yr) _____ to (Mo/Yr) _____

Please provide a brief description of your knowledge of the applicant's professional and ethical behavior:
_____
_____
_____
_____
_____
_____
_____
_____

Name of organization and the applicant's title and position at the organization at the time you worked with the applicant: _____

Brief description of applicant's duties and responsibilities:
_____
_____

Area of applicant's specialties: _____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license ~~/~~ **or** certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____
_____
_____

I attest and certify that the applicant is an individual of good professional and moral character:
[ ] Yes [ ] No

If No, please explain: _____
_____
_____

Check one of the following endorsements:

[ ] Without Reservation [ ] With Reservation [ ] Not Recommended

If you checked "With Reservation" or "Not Recommended" explain: _____
_____
_____
_____

References:

Mailing Address: _____

Phone Number: _____ Title: _____ Degree: _____

Licensed/Certified (Specialty): _____

States Licensed in: _____ License Number(s): _____

Signature of Reference _____ Date: _____

THIS FORM SHALL BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Readopt with amendment the "Summary of Supervised Clinical Experience Form – Marriage and Family Therapist" (Revised 7/2023), whose requirements are set forth in Mhp 302.05(b)(1)b., effective 12-19-23 (Document #13786), to read as follows:

BOARD OF MENTAL HEALTH PRACTICE
SUMMARY OF SUPERVISED CLINICAL EXPERIENCE FORM –
MARRIAGE AND FAMILY THERAPIST

All applicants mare required to complete this form and submit it with the application for licensure. The hours on this form should match the hours verified on the supervisor's confirmation of clinical experience form by both past and present supervisors.

APPLICANT'S NAME: _____

START & END DATE OF **EACH SUPERVISED CLINICAL EXPERIENCE**	NAME OF FACILITY **FOR EACH SUPERVISED CLINICAL EXPERIENCE**	NAME OF SUPERVISOR **FOR EACH SUPERVISED CLINICAL EXPERIENCE**	TOTAL HOURS OF **EACH INDIVIDUAL** SUPERVISION **RECEIVED FOR EACH CLINICAL EXPERIENCE**	TOTAL HOURS OF CLIENT CONTACT **FOR EACH CLINICAL EXPERIENCE**	TOTAL HOURS OF **SUPERVISED** CLINICAL EXPERIENCE **FOR EACH CLINICAL EXPERIENCE**
TOTAL HOURS OF SUPERVISED CLINICAL EXPERIENCE **FOR ALL EXPERIENCES**					

If the graduate program was COAMFTE approved you are required to document the hours on this form as well as having your supervisor complete the "Supervisor's Confirmation of Clinical Experience Form" this requirement includes post-graduate clinical hours, see MHP 306.02(f).

BY SIGNING BELOW, I CERTIFY THAT THE FOREGOING IS CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE _____ DATE _____