



SUPERVISION VERIFICATION FORM

Supervisee Name: _____ (Print)

Supervisor Name: _____ License Number: _____ State: _____ (Print)

Agency Name: _____ Agency Address Line 1: _____ (Print)

Agency Address Line 2: _____ City: _____ State: _____ Zip Code: _____ (Print)

Does this agency provide teletherapy? [] YES In which state did social work practice take place? _____

Date Supervision Started: _____ Date Supervision Ended: _____ (MM/DD/YYYY)

Supervisee Number of Hours Worked Per Week: _____

Individual Supervision Hours Provided: _____ Group Supervision Hours Provided: _____

Average Number of Hours of Direct, Face-to-Face Client Contact Per Week: _____

§ 19-302 (e)(3) and COMAR 10.42.01.02 B (6) & (&) and 10.42.01.04 G

Table with 4 columns: Clinical Social Work Experience per COMAR 10.42.02.02 B (6), YES, NO, SUPERVISOR'S INITIALS. Rows include questions about client assessments, diagnostic impressions, treatment of mental disorders, and psychotherapy.

AFFIDAVIT

I solemnly declare and affirm, under penalties of perjury, that the information contained on this Supervision Verification Form is true and correct.

Supervisor signature: _____ Date completed: _____