STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF EXPERIENCE

TO BE COMPLETED BY APPLICANT

Applicant: Complete the top portion of this form and forward to the appropriate agency where you completed post-graduate experience in marital and family therapy.

Name: _____

Date of Birth: _____/_____/_____ Telephone Number: _____

Dates of Experience from _____ to _____

TO BE COMPLETED BY AGENCY

The above individual is applying for marital and family therapy licensure in Connecticut. Please provide the following information:

Name and address of agency, institution or office where the candidate completed postgraduate work experience:

_____

_____

_____

Dates of postgraduate experience: From _____/_____/_____ To _____/_____/_____

How many actual months of postgraduate experience did the candidate engage in? _____

How many hours of direct client contact did the candidate engage in? _____

Do you have any derogatory information regarding the competency or conduct of the applicant? YES ☐ NO ☐

If yes, please explain (attach additional sheet if necessary): _____

_____

My knowledge in this matter is based on: ☐ personnel records ☐ personal experience with applicant

_____
Printed Name & Title of Person Completing Form

_____ _____
Signature Date

Telephone Number: _____ Email:_____

This form must be returned by the agency directly to:

DEPARTMENT OF PUBLIC HEALTH
MARITAL AND FAMILY THERAPY LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308