

**Alaska Board of Marital and Family Therapy
WEEKLY SUMMARY OF HOURS OF EXPERIENCE**

Associate Name: _____ **Associate MFT #:** _____

Signature of MFT Associate: _____

Name of Supervisor: _____ **License #:** _____

Work Setting: _____
Name and Address of Setting

Year of: _____

WEEK OF: _____ mm/dd - mm/dd															Total Hours	Cum. Hours
Individual Psychotherapy																
Couples, Families, and Children																
Group Therapy or Counseling																
Telephonic / Cyber Counseling																
Supervision, Individual Face to Face																
Supervision, Group																
TOTAL HRS PER WEEK																
Signature of Supervisor, and if applicable, Agency Supervisor who verifies clinical hours																

** This is a Weekly Summary of Hours of Experience form intended for the use of associates and supervisors. This is simply a template—other similar forms are sufficient.*