**MEMORANDUM OF UNDERSTANDING**

Advisor Name at Advanced Practical Experience Site: Date, year

Department

Agency/Organization

Address

Dear *Supervisor/Mentor,*

*Student name* (hereinafter referred to as student), a doctoral student in the Couple and Family Therapy Program at the University of Iowa, has expressed interest to do an Advanced Practical Experience (APE) at *Name of Agency/organization* (hereinafter referred to as the Agency) from *date of APE* to satisfy the requirements for PSQF: Advanced Clinical Experience in Couple and Family Therapy. Such an arrangement would be subject to the following conditions:

1. Participation in PSQF: APE will not relieve the student of adhering to any policy of the Agency.
2. The Agency will provide the student with a supervised experience of at least 9 months in duration emphasizing relationally-focused experience.
3. Whether supervised by the CFT Program at the University of Iowa or not, the Agency agrees to give the student consistent individual or group supervision during the APE if it is a clinical experience.
4. The CFT Program at the University of Iowa faculty will treat any client information revealed during supervision as confidential.
5. The University of Iowa will provide professional liability insurance for the student as a component of their enrollment in PSQF: APE.

Below are the expectations of the student’s Advanced Practical Experiences (APEs). The student is expected to:

* Student lists the 1 area of APE that the student is doing for APE.

Provide a brief description of the tasks and what you hope to gain

* Student lists the 1 area of APE that the student is doing for APE.

Provide a brief description of the tasks and what you hope to gain

Below, please outline the role of the mentor/supervisor in helping the student attain the two Advanced Practical Experiences described above.

* For APE 1, the mentor/supervisor will…
* For APE 2, the mentor/supervisor will…

If the student is participating in a clinical experience, please provide the supervision credentials of the supervisor

**\_\_\_\_AAMFT Approved Supervisor**

**\_\_\_\_AAMFT Approved Supervisor Candidate**

**\_\_\_\_Supervisory Equivalence**

If supervisory equivalence, please provide a CV and proof that they can supervise systemically with the first monthly APE form. Proof may include a transcript of a course they have taken related to CFT theories, documentation of publications or presentations that highlight systemic thinking.

**For the CFT Program For the Agency**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_