

FORM 2

VERIFICATION OF 2000 HOURS OF SUPERVISED CLINICAL EXPERIENCE

- Form 2 needs to be completed if candidate's state of residence does not require or have licensure, or if licensure or credential does not require 2000 supervised clinical hours.

Name of Candidate _____

Name of Clinical Supervisor _____

Title and Education of Clinical Supervisor _____

Address of Clinical Supervisor _____

Phone/email of Clinical Supervisor _____

Type of facility in which clinical supervision took place (e.g. clinic, hospital etc.) _____

List all dates and number of hours:

I certify that the above information is correct to the best of my knowledge.

Clinical Supervisor Signature

Date

See Chapter Three for more information.