BOARD OF PSYCHOLOGY
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CALIFORNIA BOARD OF PSYCHOLOGY

VERIFICATION OF EXPERIENCE FORM

THIS FORM IS TO BE COMPLETED BY THE PRIMARY SUPERVISOR UPON COMPLETION OF THE SUPERVISED PROFESSIONAL EXPERIENCE. THE PRIMARY SUPERVISOR SHALL COMPLETE THIS FORM, ATTACH IT TO THE *SUPERVISION AGREEMENT FOR SUPERVISED PROFESSIONAL EXPERIENCE IN HEALTH SERVICES* OR TO THE *PLAN FOR ALTERNATIVE SUPERVISED PROFESSIONAL EXPERIENCE IN NON-MENTAL HEALTH SERVICES* (WHICHEVER PERTAINS) AND SEND THE DOCUMENTS DIRECTLY TO THE BOARD OF PSYCHOLOGY.

TRAINEE

Name: Last First M.I.	AKAs/Aliases: Last First M.I.	Date of Birth:

Email Address	Telephone Number

Registration Number (if applicable)

PRIMARY SUPERVISOR

Name: Last First M.I.	Telephone Number	Email Address

Address: Street	City	Zip

License Type	License Number	Issue Date	Jurisdiction (State or Province)

VERIFICATION OF EXPERIENCE

Starting Date	Completion Date	# of hours worked per week	Total # of hours of supervision per week including delegated or group supervision	Total # of hours being verified as meeting performance at or above the expected level of minimal competency during this period.

ALL OF THE CONDITIONS AND ACKNOWLEDGEMENTS SET FORTH IN THE *SUPERVISION AGREEMENT FOR SUPERVISED PROFESSIONAL EXPERIENCE* WERE COMPLIED WITH BY THE TRAINEE AND MYSELF. Yes _____ No _____

THE TRAINEE DEMONSTRATED OVERALL PERFORMANCE AT OR ABOVE THE LEVEL OF MINIMAL COMPETENCE EXPECTED FOR HIS/HER CURRENT LEVEL OF TRAINING. Yes _____ No _____

NOTE: IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS "NO," PLEASE THOROUGHLY EXPLAIN ON A SEPARATE SHEET AND ATTACH IT TO THIS FORM AS AN ADDENDUM.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL THE FOREGOING IS TRUE AND CORRECT.

Primary Supervisor's Name ____
(Print or Type)

Primary Supervisor's Signature ____

City/State ____

Date ______________________________

(**Revised 04/13/06)**