Clinical Associates

Verification of Supervised Postdoctoral Experience Form

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF POST DOCTORAL EXPERIENCE FORM:

• The primary supervisor shall complete and sign a verification of experience form upon completion of supervised professional experience accrued. This form is provided for your convenience to help you meet requirements.

• Provide this completed form and the original signed supervision agreement to the supervisee in a sealed envelope and sign across the seal.

• The supervisee shall submit the sealed envelope along with their application.

• Please make a copy for your records.

• Please note that if the form is incomplete, it could cause a delay in the application process.

Supervisee:

_____ _____ ____ _____

Last Name First Name M.I. Date of Birth

_____ _____ _____

E-mail address Phone Number Registration Number (if applicable)

Primary Supervisor:

_____ _____ _____

Last Name First Name M.I.

_____ _____

E-mail address Phone Number

Training Director:

_____ _____ _____

Last Name First Name M.I.

_____ _____

E-mail address Phone Number

VERIFICATION OF POSTDOCTORAL EXPERIENCE REQUIRED FOR LICENSURE

Start Date	**Completion Date**	**Number of Hours Worked per seek (excludes supervision)**	**Number of hours of supervision per week**	**Total Number of Hours of Verified Experience** (Weeks x Number of Hours Worked/wk + Weeks x Supervision Hours/wk

☐ The supervisee and I complied with all the conditions and acknowledgments set forth in the Supervision Performance Agreement

☐ The supervisee demonstrated overall performance at or above the level of competence expected for licensure for his or her current level of training.

NOTE: If supervisor did not check one or both boxes above, 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 Kansas that all the foregoing is true, complete, and correct.

Primary Supervisor's Name (Print or Type) _____

Primary Supervisor's Original Signature _____ Date _____

City/State _____