

**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	# of hours of supervision per week	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 02/15/05)