Verification of Supervised Post-Graduate Experience

Each supervisor must complete a separate form.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

License Number: _____ **State of Issue:** _____

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of APRN Supervisor: _____ **License Number:** _____

Name of Licensed Mental Health Therapist Supervisor (if applicable): _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Number of supervised clinical practice hours (a total of 2000 hours is required): _____

Number of supervised mental health practice hours (a total minimum of 1000 hours is required) _____

Describe the applicant's duties: _____

_____

_____

I do hereby attest that the applicant for licensure as an APRN specializing in Psychiatric Mental Health Nursing has successfully completed the hours of post-graduate supervised experience as listed above. I certify that the experience supervised meets the requirements outlined in R156-31b-301c.

Signature of Supervising License Mental Health Therapist (If applicable):

_____ **Date:** _____

Signature of Supervising APRN: _____ **Date:** _____