State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Verification of Supervised Post-Graduate Experience

Each supervisor must complete a separate form.
Total of all forms must document at least 2,000 clinical practice hours and 1000 mental health practice hours.

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: _____

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

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

APRN Supervisor Phone: _____ **APRN Supervisor Email:** _____

Name of Licensed Mental Health Supervisor (if applicable): _____

Mental Health Supervisor License Number: _____

Applicant's Dates of Employment: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Number of supervised clinical practice hours: _____

Number of supervised mental health practice hours: _____

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 APRN Supervisor: _____ **Date:** _____

Signature of Mental Health Supervisor: _____ **Date:** _____
(if applicable)