STATE OF CALIFORNIA

TERMINATION OF SUPERVISION

1800 37A-518 (NEW 11/98)

BOARD OF BEHAVIORAL SCIENCES
400 R ST., SUITE 3150, SACRAMENTO, CA 95814-6240
TELEPHONE:(916)445-4933 TDD:(916)322-1700
WEBSITE ADDRESS: http://www.bbs.ca.gov

Associate's Name	ASW Number
Supervisor's Name	

I, _____ certify that I supervised
_____,

in the field of clinical social work in accordance with Section 4996.21.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing and that I meet with all the criteria stated therein and the information submitted on this form is true and correct.

_____ _____ _____
Printed Name of Qualified Supervisor *Signature of Qualified Supervisor* *Date*

_____
Mailing Address: Number and Street City State Zip Code

Qualified Supervisor's Daytime Telephone Number: ( )_____

The **original** of this form must be mailed to:

Board of Behavioral Sciences
400 R St., Suite 3150
Sacramento, CA 95814

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