Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830
www.bbs.ca.gov

PROFESSIONAL CLINICAL COUNSELOR
IN-STATE Experience Verification

This form is to be completed by the applicant's California supervisor and submitted by the applicant with their *Application for Licensure*. All information on this form is subject to verification.

- Use separate forms for each supervisor and each employment setting.
- Ensure that the form is complete and correct prior to signing.
- Supervisor must initial any changes.
- Do not submit *Weekly Log* forms unless specifically requested.
- Please see the Notice on Collection of Personal Information *(access at www.bbs.ca.gov>About Us>About the Board>Other Information>Policies).*

APPLICANT NAME:

Last	First	Middle	Associate Number APC

Dates of experience being claimed (mm/dd/yyyy):	From:	To:

SUPERVISOR INFORMATION:

Supervisor's Name		Email Address *(if supervisor has one)*	
Business Phone	License Type	License Number	Date First Licensed*

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ N/A ☐ No ☐ Yes: Date Certified: _____
  Certification Number: _____

**If licensed in California for less than two years on the first date of experience claimed by the applicant, attach your out-of-state license information*

Were you (the supervisor) employed by the supervisee's employer? ☐ Yes ☐ No

If NO, did you and the supervisee's employer sign a written agreement pertaining to oversight of the supervisee? ☐ Yes ☐ No *If YES, applicant must submit a copy of this agreement.*

Applicant: Last	First	Middle

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer			Business Phone
Address: Number and Street	City	State	Zip Code

1. Was this experience gained in a private practice or professional corporation setting?	☐ Yes ☐ No
2. Was the applicant receiving pay? *If YES, applicant must submit a copy of their W-2 statement for each year experience is claimed (if a W-2 has not yet been issued for this year, submit a copy of the current paystub).* *If NO (applicant volunteered), applicant must submit a letter from the employer verifying volunteer status.*	☐ Yes ☐ No

EXPERIENCE INFORMATION:

1. Dates of experience (mm/dd/yyyy):	From:	To:

2. Number of weeks of supervised experience:	
3. Hours of Experience:	**Logged Hours**
a. Total Direct Clinical Counseling Experience:	
b. Total Non-Clinical Experience:	
• Of the above hours, how many were Face-to-Face Supervision?	**Logged Hours**
○ Individual or Triadic Supervision:	
○ Group Supervision:	

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.

Signature of Supervisor: _____ Date: _____

ORIGINAL OR ELECTRONIC SIGNATURE REQUIRED