



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](http://www.bbs.ca.gov/About/About%20the%20Board/Other%20Information/Policies) (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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Was the applicant receiving pay? <i>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).</i> <i>If NO (applicant volunteered), applicant must submit a letter from the employer verifying volunteer status.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> 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