

## **Board of Behavioral Sciences**

1625 North Market Blvd., Suite S200, Sacramento, CA 95834 Telephone: (916) 574-7830 TTY: (800) 326-2297 www.bbs.ca.gov



The hours on this

form were earned

as (mark one):

## IN-STATE EXPERIENCE VERIFICATION OPTION 1 – NEW STREAMLINED METHOD

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

Use this "Option 1" form to report hours under the NEW streamlined method

Use separate forms for pre-degree and post-degree experience

<ul> <li>Use separate forms for each state.</li> <li>Ensure that the form is complete.</li> <li>Provide an original signature are.</li> <li>Do not submit your Weekly Suby the Board.</li> </ul> APPLICANT NAME:	e and corre	ect prior superv	to sigr isor ini	ning tial any char	iges	☐ Pre-Degree ☐ Post-Degree ☐ Practicum Remediation	
Last	First			Middle		Intern Number	
						IMF	
SUPERVISOR INFORMATION:							
Supervisor's Last Name			First			Middle	
Address: Number and Street	:						
City	Sta	te	Zip Code		В	Business Phone	
License Type	Licens	License Number		State		Date First Licensed	
If a Physician, were you certified in during the entire period of supervise	· · ·			s: Date Boa	rd Certifi	try and Neurology ed:	
<ul> <li>If a LPCC, did you meet the qualification</li> <li>supervision, as specified in Californ</li> </ul>			•		•	•	
37A-301 (Revised 04/2016)		1 of 2					

Applicant: Last		First		Middle					
APPLICANT'S EMPLOYER INFORMATIO	N:								
Name of Applicant's Employer			Busines	ness Phone					
Address Number and Street		City	State	Zip Code					
1. Was this experience gained in a setting that lawfully and regularly provides mental									
2. Was this experience gained in a private practice setting?									
3. Was this experience gained in a setting that provided oversight to ensure that the Yes No applicant's work meets the experience and supervision requirements and is within the scope of practice?									
4. For hours gained as an Intern ONLY: We lif YES, attach a copy of the applicant's list claimed. If a W-2 has not yet been is current paystub. If applicant volunteered verifying volunteer status.  EXPERIENCE INFORMATION:	W-2 stater sued for th	nent for each ye is year, attach a	ar experier		Yes				
Dates of experience being claimed:  F	-rom:	mm/dd/yyyy	mm/c	ld/yyyy					
2. How many weeks of supervised experience	ce are beir	ng claimed?	W	eeks					
3. Hours of Experience:		Logged Hours							
a. Total Direct Counseling Experience (N									
<ul> <li>Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? (Minimum 500 of the 1,750 hours)</li> </ul>									
b. Total Non-Clinical Experience (Maximu	um 1,250 F	nours)							
<ul> <li>Of the above hours, how many wer Supervision?</li> </ul>	Hours Per	Week	ek Logged Hours						
Individual									
Group (group contained no more the									
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.									
Signature of Supervisor:				Date:					