

Mail to: Licensure Unit
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FOR LIMHP - AFFIDAVIT OF SUPERVISED EXPERIENCE
Supervisor must complete this form
DO NOT USE WHITE OUT OR ALTER THIS FORM

SECTION A: SUPERVISOR INFORMATION

1	Supervisor's Name:	First:	Middle:	Last:
2	Address Information	Street/PO/Route:		
		City:	State:	Zip:
3	Indicate the Type of License you hold:	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist <input type="checkbox"/> Independent Mental Health Practitioner License # _____ Date it was Issued to you : _____		
4	Name of person you supervised:	First:	Last:	

SECTION B: SUPERVISED EXPERIENCE

OPTION 1 or OPTION 2: If the applicant is applying under either Option 1 or 2, provide the following information:

I supervised the applicant **for at least 3,000 hours** (or more) of mental health practice experience (regardless of whether it was direct or non-direct hours), **including at least 1,500 hours** (or more) of experience with clients diagnosed under the major mental illness or disorder category.

OR

I supervised the applicant for **less than 3,000 hours**.
 # _____ List the total number qualifying mental health practice hours you supervised this applicant
 # _____ How many of those hours included experience with clients diagnosed under the major mental illness/disorder category

AND The applicant's total experience must have been obtained under supervision by a licensed physician, licensed psychologist, or licensed independent mental health practitioner.

The hours listed above were earned under MY supervision: From _____ to _____.
(month/day/year) (month/day/year)

City/State where Experience was completed: _____

OR

OPTION 3: If the applicant is applying under this option, provide the following information:

I supervised the applicant **for a total of at least 7,000 hours** of mental health practice (regardless of whether it was direct or non-direct hours) and of these hours **at least 3,500 hours included experience with clients diagnosed** under the major mental illness or disorder category.

OR

I supervised the applicant for **less than 7,000 hours**.
 # _____ List the total number of qualifying mental health practice hours you supervised this applicant
 # _____ How many of those hours included experience with clients diagnosed under the major mental illness/disorder category

AND The applicant's total experience must have been obtained in **10 years** or more and have been **supervised** by a licensed physician, a licensed psychologist, or a licensed independent mental health practitioner

The hours listed above were earned under MY supervision: From _____ to _____.
(month/day/year) (month/day/year)

City/State where Experience was completed: _____

Supervisor Signature: I state that I am the supervisor completing this form and the statements are true and complete.

 (Print/type) Name of Supervisor Signature: _____ Date Signed: _____