NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Licensure Unit
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FOR MHP LICENSURE
POST-MASTER's SUPERVISED EXPERIENCE VERIFICATION

Supervisors must complete this Attachment. Each supervisor **MUST** sign and date this form to attest to the experience earned. **These hours MUST be earned after receipt of an approved masters' degree.**

WHITE OUT IS NOT ACCEPTABLE:

Changes to information entered onto this form are not acceptable unless the supervisor initials the changed information.

PART I - SUPERVISOR INFORMATION:

Name of Supervisor: _____ License #: _____

Name of Applicant: _____

Supervisor place a checkmark in the box by the license(s) you hold:

☐ licensed mental health practitioner (LMHP)	☐ licensed independent mental health practitioner (LIMHP)
☐ licensed psychologist	☐ qualified physician

PART II - MENTAL HEALTH PRACTICE EXPERIENCE: MHP Activities include: treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, couples, families, Or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations.

SUPERVISORS: List only hours that you personally supervised the applicant providing mental health services
NOTE: direct and non-direct hours are reported separately:

1. _____ Number of direct (face-to-face) client contact (clock) hours (when reporting partial hours, use .25 increments)
2. _____ Number of **non-direct** clock hours
3. _____ Total number of clock hours of mental health activities performed under my supervision.
4. List the dates the above hours of supervised mental health practice **was completed (provide FULL dates)**:

from _____ through _____
(month/day/year) (month/day/year)

Supervisor's Signature and Attestation

I state that I am the person completing this form and the statements on this form are true and complete
AND
I have met with the applicant face-to-face for at least 1 hour per week, for hours reported above.

_____ Date Signed : _____
(Print/type) SUPERVISOR Name and Title

_____ Telephone Number: _____
Signature

_____
AGENCY/INSTITUTION

_____ _____
STREET ADDRESS CITY STATE ZIP