NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
Division of Public Health – Licensure Unit
P. O. Box 94986 - Lincoln, NE 68509-4986
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Independent Mental Health Practitioner

AFFIDAVIT OF SUPERVISED EXPERIENCE

Supervisor must complete this form

Applicant's Name: _____
(Name of Person you supervised) (Print or Type)

SECTION A – SUPERVISOR INFORMATION			
1. Supervisor's Name:	First:	Middle:	Last:
1. Address Information	Street/PO/Route:		
	City:	State:	Zip:
3. Indicate the Type of License you hold:	☐ Physician License # _____ Date Issued: _____	☐ Psychologist License # _____ Date Issued: _____	☐ Independent Mental Health Practitioner License # _____ Date Issued: _____

SECTION B – SUPERVISED EXPERIENCE

OPTION 1 or OPTION 2: If the applicant is applying under this option, provide the following information:

☐ I supervised the applicant **for a total of at least 3,000** hours of mental health practice (regardless of whether it was direct or non-direct hours) and of these hours **at least 1,500 hours included 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 of hours you supervised
#_____ List the number of hours that included experience with clients diagnosed under the major mental illness/disorder category

The applicant's total experience must have been obtained in **not less than 2 years and not more than 5 years** and must have been **supervised** by a licensed physician, licensed psychologist, or licensed independent mental health practitioner.

List **FULL** Dates of experience you supervised: from _____ to _____.
(month/day/year) **(month/day/year)**

City/State where Experience was completed: _____

OR

OPTION 3: **I**f 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 hours you supervised
#_____ List the number of hours that included experience with clients diagnosed under the major mental illness/disorder category

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

List **FULL** Dates of experience you supervised: from _____ to _____.
(month/day/year) **(month/day/year)**

City/State where Experience was completed: _____

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

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