ASSOCIATE/SUPERVISED TREATMENT PROVIDER

SUPERVISED EXPERIENCE VERIFICATION

List your cumulative sexual offender-specific clinical practice hours that have been aquired toward attaining Senior/Approved level Sexual Offender Treatment Provider qualifications. (Attach additional sheet if necessary.)

Indicate Nature of Experience or Practice and Location	Experience Hours	Inclusive Dates of Experience	
		Beginning Date	Ending Date

I certify that _____ has completed _____ total hours of supervised work within the past 2 years with me/my agency as indicated above.

_____ _____

Supervisor's Signature Date