ATTACHMENT B: STATEMENT OF VERIFICATION OF POSTGRADUATE SUPERVISED HOURS			
SECTION 1: To be completed by the applicant. It is the applicant's responsibility to send this form to the appropriate supervisors.			
DATE:	SUPERVISOR'S NAME:		
APPLICANT'S NAME:			
SECTION 2: To be completed by the supervisor. Please mail completed form directly to the Board Office on behalf of the supervisee, or, provide back to the supervisee in a sealed envelope with your signature across the seal.			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY:	STATE:	ZIP CODE:
LICENSE TYPE:	LICENSE NUMBER:	STATE:	ISSUE DATE:
LOCATION OF SUPERVISION/CLIENT CONTACT HOURS:			
BEGINNING DATE OF SUPERVISION (MM/DD/YYYY):	ENDING DATE OF SUPERVISION (MM/DD/YYYY):	NUMBER OF SUPERVISION HOURS:	NUMBER OF DIRECT CLIINICAL CLIENT CONTACT HOURS:

SECTION 3: AFFIDAVIT

1. I declare under penalty of perjury under the laws of the State of New Mexico that the above information is true and correct. I further certify that this individual is competent to receive a license in the area in which supervision was given.

2. The undersigned, being duly sworn, upon their oath deposes and says that they are the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application form, the undersigned also acknowledges that the supervisee received the above supervision. **I certify that all of the statements made in this Attachment B form are true, complete, and correct to the best of my knowledge and my belief, and are made in good faith.**

Supervisor's Signature ____ Date ____________________