



VERIFICATION of POST-DEGREE SUPERVISION

IMPORTANT NOTICE:

The applicant should complete the top portion of this form **only**, then provide this form to the supervisor who supervised the applicant's post-degree experience. The completed form containing the original signature of the supervisor, should be returned to the applicant for inclusion in their application packet that must be mailed to the Virginia Board of Psychology. **If supervision took place under more than one supervisor, a separate form is required for each.**

TO BE COMPLETED BY APPLICANT/TRAINEE

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Email Address:		Last 4 digits of Social Security Number: XXX-XX- ____ - ____ - ____ - ____	

TO BE COMPLETED BY SUPERVISOR:

Part I: Supervisor's Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Email Address:		Supervisor's Phone Number:	
CSTOP Certification Number:		License Number:	

Part II: Worksite Information *(location where supervisee obtained post-master's degree experience)*

Name of Worksite:		
Address of Worksite:		
City:	State:	Zip Code: ____ - ____ - ____

Part III: Dates of Supervision

Start Date: (MM/DD/YYYY) ____ / ____ / ____	End Date: (MM/DD/YYYY) ____ / ____ / ____
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Part IV: Hours & Competencies *(Answers to the below questions should be provided based on the supervision obtained under the instructions of the supervisor completing this form. If the response is "NO" to any of the below questions, please provide an explanation on a separate sheet of paper and provide it with this form to the applicant.)*

a. Did the applicant receive a minimum of six (6) hours per month of face-to-face supervision?	<input type="checkbox"/> YES <i>Exact # of Hours Received</i> _____	<input type="checkbox"/> NO <i>If not, how many hours</i> _____
b. Did the applicant complete a minimum of 2,000 hours of supervised post-degree experience in the delivery of clinical assessment/treatment services while under your direct supervision?	<input type="checkbox"/> YES <i>Exact # of Hours Received</i> _____	<input type="checkbox"/> NO <i>If not, how many hours</i> _____
c. How many hours of individual face-to-face supervision hours did the applicant receive?	_____	
d. How many hours of group face-to-face supervision did the applicant receive?	_____	



e. Did the applicant demonstrate minimum competencies of sex offender assessment while under your direct supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Did the applicant demonstrate minimum competencies of sex offender treatment interventions while under your direct supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Did the applicant demonstrate minimum competencies of etiology/development issues of sex offense behavior while under your direct supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Did the applicant demonstrate minimum competencies of criminal justice and legal issues related to sexual offending while under your direct supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Did the applicant demonstrate minimum competencies of program evaluation, treatment efficacy and issues related to recidivism of sex offenders while under your direct supervision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. In your opinion has the applicant demonstrated competency in providing sex offender treatment services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. In your opinion does the applicant need any additional supervision or training prior to being certified as a sex offender treatment provider?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Part V: Declaration of Supervisor

I, _____ (name of supervisor) declare by my signature, to the best of my knowledge the foregoing is true and correct.

Signature of Supervisor

Date