



Virginia Department of  
**Health Professions**  
Board of Counseling

9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
[www.dhp.virginia.gov/counseling](http://www.dhp.virginia.gov/counseling)

Email: [coun@dhp.virginia.gov](mailto:coun@dhp.virginia.gov)  
(804) 367-4610 (Tel)  
(804) 527-4435 (Fax)

## VERIFICATION OF EXPERIENCE FOR REHABILITATION PROVIDER CERTIFICATION

**This form is to be filled out by the supervisor when supervision is completed.  
Submit one form for each supervisor verifying experience.**

<b>I. APPLICANT INFORMATION</b> (To be completed by applicant)				
Applicant's Name:			Social Security or DMV Control Number:	
<b>II. SUPERVISOR INFORMATION</b>				
Name: _____ Social Security or Virginia DMV Control Number _____				
Business Address: _____ Telephone _____				
Number of years experience in provision of rehabilitation services:				
License/Certificate Title (Submit Form 4 if out-of-state)	Number	Issuing State or Agency	Initial Date of Licensure/ Certification	Expiration Date
<b>III. PERIOD OF SUPERVISION</b> From: _____ To: _____				
<b>IV. TYPE OF EXPERIENCE APPLICANT RECEIVED UNDER YOUR SUPERVISION</b>				
___ Internship (Applicant must submit an official transcript documenting completion of the internship)				
___ In-Service Training				
___ On-the-Job Experience				



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**V. DOCUMENTATION OF TRAINING.** The regulations define “*Training*” as “*the educational component of on-the-job experience.*” Copies of certificates or diplomas must be included with this form to document in-service training. If this documentation is not available, the supervisor must verify the training by signature. Training, alone or in combination with work experience must add up to 2,000 clock hours. One C.E.U. is equivalent to one clock hour.

Course or Workshop	Content	Clock Hours	Supervisor’s Signature

**TOTAL HOURS OF TRAINING:**

**VI. DOCUMENTATION OF WORK EXPERIENCE**

Duties performed by applicant under your supervision:

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**TOTAL HOURS OF WORK EXPERIENCE:**

**VII. PERSONAL INSTRUCTION**

Hours of personal instruction \_\_\_\_\_ Per week (avg.): \_\_\_\_\_ Total: \_\_\_\_\_  
 Hours of personal instruction that was face-to-face: \_\_\_\_\_ Total \_\_\_\_\_

**VIII. ASSESSMENT OF COMPETENCE**

In your opinion, has the applicant demonstrated competency in rehabilitation services sufficient for certification? Yes [ ] No [ ]  
 If no, please explain. Include any additional supervision or training that you feel the applicant needs:

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**IX. DECLARATION:** I declare that to the best of my knowledge, the foregoing is true and correct.

\_\_\_\_\_  
 Supervisor Signature

\_\_\_\_\_  
 Date