UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

VERIFICATION OF SUPERVISED POST-GRADUATE EXPERIENCE

Each supervisor must complete a separate form.
Total of all forms must document at least 2,000 clinical practice hours and 1000 mental health practice hours.

APPLICANT INFORMATION
(TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ State of Issue: _____

EMPLOYMENT INFORMATION:
(TO BE COMPLETED BY THE LICENSED SUPERVISOR.)

Name of Establishment: _____

Establishment Address: _____ City: _____ State: _____ Zip: ____

Supervisor Name: _____ _____ License Number: _____
First *Last*

Supervisor Phone: (___) _____ –_____ Supervisor Email: _____

I am a licensed *(check one)*:

- ☐ **APRN** specializing in psychiatric mental health
- ☐ **ABPN certified physician**
- ☐ **Mental Health Therapist** delegated to supervise by:

APRN delegator Name: _____ *License Number:* _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Total supervised clinical practice hours: _____

Number of supervised mental health practice hours: _____

Describe the applicant's duties: *(attach additional forms if needed)*

ATTESTATION:

I do hereby attest that the applicant for licensure as an APRN specializing in Psychiatric Mental Health Nursing has successfully completed the hours of post-graduate supervised experience as listed above. I certify that the experience supervised meets the requirements outlined in R156-31b-302e(2).

I declare under criminal penalty under the law of Utah that this verification is true and correct.

Signature of Supervisor: _____ Date: _____

Signature of Mental Health Supervisor: _____ Date: _____
(if applicable)