STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
BOARD OF PSYCHOLOGISTS

7 Eagle Square Suite 300
Concord, NH 03301
(603) 271-2152

SUMMARY OF SUPERVISED CLINICAL EXPERIENCE

To be completed by the applicant and sent directly to the Board with the application.

APPLICANT'S NAME _____

APPLICANT'S ADDRESS _____

DATE	FACILITY	SUPERVISOR	TOTAL HOURS OF FACE-TO-FACE SUPERVISION	TOTAL HOURS OF CLINICAL EXPERIENCE
TOTAL HOURS OF SUPERVISED CLINICAL EXPERIENCE				

BY SIGNING BELOW, I CERTIFY THAT THE FOREGOING IS CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANTS SIGNATURE_____DATE _____