State of New Hampshire
The Office of Licensed Allied Health Professionals
Philbroek Building, 121 South Fruit Street, Concord NH 03301
603-271-8389

SUPERVISION FORM
To be completed by the person to be supervised:
(This information is about the person to be supervised)

Name of person to be supervised _____________________________________   License #: _________

Purpose of supervision: _____________________________________________

To be checked if supervision is of an Assistant   ☐

Place of Employment Name: __________________________________________
Place of Employment Address: _________________________________________
   (Street # or P.O. Box #, City, State and Zip)
Place of Employment Phone #: _______________________________________

To be completed by the Supervisor:
(This information is about the supervisor)

Name: ______________________________________________  Profession: _____________________
License #: ___________________  State of Licensure: _________________________________
Place of Employment Name: __________________________________________
Place of Employment Address: _________________________________________
   (Street # or P.O. Box #, City, State and Zip)
Place of Employment Phone #: _______________________________________

Site of supervision:  (This is the actual location where the supervision to take place)

Site Name: _________________________________________________________
Physical Location of the Site: __________________________________________
   (Street, City, State and Zip)
Phone number of the Site of Supervision: ______________________________

Date Supervision Started: _____________  Date Supervision Ended: _____________

By signing this form, I state that I have read and understood the applicable rules of supervision or order of
the Board for supervision, agree to undertake the duties of supervision set forth in the rules or order of the
Board, agree to be responsible for the acts and omissions of any person to whom I delegate the duties of
supervision, and acknowledge that my own or my delegate’s failure to comply with the rules or order of
the Board might result in disciplinary sanctions.

Signature of supervisor _____________________________ date ______________

Please note: If there is a change in Supervisors, the new Supervisor should fill out a new copy of this Supervision
Form and submit it to the Governing Board. To obtain a new form visit our web site, www.nh.gov/alliedhealth.