NEW HAMPSHIRE
PLC
Office of Professional Licensure and Certification

State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION

Allied Health
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

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.