

SUPERVISOR VERIFICATION FORM

INSTRUCTIONS TO COMPLETE THIS FORM

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK.

1. Each of your supervisor(s) must complete and submit a separate form. This form may be duplicated.
2. Your supervisor must submit all pages of this form directly to the Board.
3. Completed form mailed to: HEIP MSU, 1702 Highland Center, Mankato, MN 56001

APPLICANT INFORMATION

Last Name	First Name	Middle Initial
Position Held:		

SUPERVISOR INFORMATION

Agency/employer name position reported on this form:			
Agency Address:			
City:	County:	State:	Zip Code
RECORD FULL-TIME & PART-TIME PRACTICE DATES & NUMBER OF PART-TIME HOURS PER WEEK FOR THE POSITION REPORTED			
Full-Time	FROM: (mo/yr)	TO: (mo/yr)	
Part-Time	FROM: (mo/yr)	TO: (mo/yr)	Number of hours per week:

RECOMMENDATION BY THE SUPERVISOR

(SUPERVISOR MUST COMPLETE THIS SECTION BY CIRCLING RESPONSE)

Yes	No	Do you attest that the applicant has not engaged in misconduct
Yes	No	<p>Please answer the following questions:</p> <ol style="list-style-type: none"> 1. Development of professional knowledge, skills and values 2. Ensuring continuing competence 3. Ethical standards of practice 4. In your experience does the applicant work well with patients/clients 5. Does the applicant handle stressful situations well 6. Would you recommend the applicant for the "CHW Grandfathering Certification <p style="text-align: center;">If you answered "No" to any of these questions, please attach an explanation.</p>

Affirmation: I hereby affirm that I directly supervised the named applicant. I also affirm that the information I have provided is true and correct to the best of my knowledge. I understand that this information will be used to evaluate if the applicant meets the requirements for approval to complete the "CHW Grandfathering Certification.

Supervisor Name: (Please print)	Supervisor Signature:	Date:
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