Certified Telehealth Practitioner (CTP)

Supervised Work Experience Verification Form

Supervised Work Experience Requirement: CTP applicants must have completed five (5) telehealth sessions with follow-up supervision, in one or more positions, held between January 2020 and the date of CTP application. **Hours must be documented by the applicant's supervisor on this *CTP Verification of Supervised Work Experience Form*.** An official description of the position, or a letter detailing the applicant's role, duties, and responsibilities, must be included with this verification form for the hours to be counted toward the credential requirements. If a letter is submitted, it must be written on the agency's letterhead **and** signed by a human resources/leadership staff employee.

- **Directions for Applicants**: give this form to your current or prior employer or volunteer supervisor(s) to complete and submit to the NCBBHP on your behalf.
- **Directions for Supervisor:** You have been asked to verify the supervised work experience of an individual who is applying for the Certified Telehealth Practitioner (CTP) credential issued by the National Certification Board for Behavioral Health Professionals (NCBBHP). Please complete this form and submit it and supporting documentation to the Board at apps@nationalcertificationboard.com, or by US Mail to NCBBHP 1715 South Gadsden Street, Tallahassee, Fl 32301 or by FAX at 850-222-6247.

Applicant Information

Applicant Name _____

Applicant Email Address _____

Employer/Agency Name (paid or volunteer) _____

Employer/Agency Website Address _____

Applicant Position Title _____

☐ Paid position **OR** ☐ Volunteer position

☐ Full-time position **OR** ☐ Part-time position

Supervisor Information and Attestation

Supervisor Name _____

Supervisor Email Address _____

Supervisor Title _____

Employer/Agency Name _____

I understand that the Certified Telehealth Practitioner (CTP) Supervised Work Experience Requirement is five telehealth sessions with follow up supervision. Supervised sessions occurred between January 2020 and the date of application.

Applicant's Position Title: _____

Applicant Position is/was: ☐ Paid or ☐ Volunteer **and** ☐ Full-time or ☐ Part-time _____ (indicate hours per week)

Start Date: _____ End Date: _____ ☐ *N/A (in position at time of verification)*

Type of Documentation Attached: ☐ Official position description
☐ Agency letter detailing role and responsibilities (on letterhead, signed by leadership)

Are there any documented concerns about the applicant's on-the-job performance that would negatively impact their eligibility to earn the Certified Telehealth Practitioner credential? ❒ Yes* ❒ No

**If yes, please attach a description of the concerns.*

By my signature, I attest that the information provided and attached to this form is true, and I consent to an interview to discuss the documentation if requested by NCBBHP staff.

Verifier Signature (*NCBBHP accepts both manual and electronic signatures)* _____ **Date** _____