KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES Supervised Professional Experience Documentation

The applicant shall complete Parts 1 and 2 and signs the back of this form.

The **supervisor** shall complete Parts 3 and 4 of this form within 30 days of completion of the supervised postgraduate professional experience.

Applicant Name	FIRST	MI	Other last r	name used
AddressStreet	PO Box City	Stat	te Zij	n
Telephone: Work ()	Home ()_		21	۲
Temporary License Number	Issue Date_		Expiration Date	
Part 2 EMPLOYMENT INI	FORMATION			
Name of Employer				
Employing Agency				
AddressStree				
Stree	t PO Box	City	State	Zip
Business Telephone ()				
Business AddressAgency/Bus		Box City	State	Zip
Business Telephone ()				
Kansas License Number		Expiration Date		
Part 4 SUPERVISOR'S R				
	riod Began On Supervision Period Ended On			
 Supervision Period Began On		•		
	applicant work? 3	35 or more		
 Supervision Period Began On	applicant work? 3	35 or more 25-34		
 Supervision Period Began On	applicant work? 3	35 or more 25-34 20-24		
 Supervision Period Began On	applicant work? 3	35 or more 25-34 20-24		
 Supervision Period Began On	applicant work? 3	35 or more 25-34 20-24 15-19 contact, i.e., ass		

(Over)

A only for the months that this report covers.

Chart A: Supervision

Month of Supervision	Number of Onsite Hours	Number of Hours of Other Monitoring Activities		
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
Total Hours Total Number of Activities				

Chart B: Time Requirements

Required Number of Months When Working the Following Number of Hours Each Week		
15-19 hours/week must work 18 months		
20-24 hours/week must work 15 months		
25-34 hours/week must work 12 months		
35+ hours/week must work 9 months		

Based upon your monitoring and evaluation of the applicant, do you find supervised postgraduate experience? Yes No	the applicant has satisfactorily completed the
If no, please explain: I have discussed this report with the applicant and attest that the information of the control of	ation as reported is correct.
Signature of Supervisor	Date
Applicant: I have read and discussed this report with my supervisor and: I concur with the supervisor's report or I do not concur with the supervisor's report.	
Signature of Applicant	Date