

Licensed Professional Counselor
ATTESTATION OF SUPERVISED CLINICAL EXPERIENCE

I hereby certify and attest that I meet the Blue Cross and Blue Shield of North Carolina credentialing criteria for “Other Master’s Prepared Therapists” in that I have completed 3,000 hours of post-master’s degree clinical practice under the supervision of a state-licensed practitioner in my area of specialty. I understand that if this information is subsequently found to be false, any agreement I may have with Blue Cross and Blue Shield of North Carolina and its affiliates will be terminated.

I hereby grant permission and consent for Blue Cross and Blue Shield of North Carolina and/or its designee, to obtain and verify information pertaining to my supervised experience. I consent to the release by the person, organization, or other entity to Blue Cross and Blue Shield of North Carolina and/or its designee, of all information that may be reasonably relevant to an evaluation of my supervised experience. I agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to Blue Cross and Blue Shield of North Carolina and/or its designee.

Provider Signature

Date

Provider Name (Please print)

Supervisor’s Name: _____

Location (City, State): _____

Duration of Supervision: _____

(Beginning and End Dates)

Number of Hours at each Site*: _____

****If more than one site please attach additional sheets***