



MONTHLY

Experience Verification Form: Multiple Supervisors at One Organization



Instructions: Please complete one form per organization, per experience type.

Month/Year: _____

Trainee Name: _____ BACB Account ID: _____

Experience Type (Select One): Supervised Independent Fieldwork Practicum Intensive Practicum

State Where Experience Occurred: _____ Country Where Experience Occurred: _____

Responsible Supervisor Name: _____ BACB Account ID: _____

Responsible Supervisor Qualification Type (Select One): BCBA/BCBA-D Verified Experience Instructor ABPP/ABA

Experience Hours (this month only)

A. Independent Hours (supervisor not present): _____

B. Supervised Hours (supervisor present): _____

Total Experience Hours (add A & B): _____

Responsible Supervisor and Trainee Attestation

By signing below, we hereby attest that:

- ▶ The information contained on this form is true and correct to the best of our knowledge;
- ▶ All supervisors, including the responsible supervisor, met BACB supervision requirements during this month;
- ▶ The required number of supervisory contacts occurred during this month;
- ▶ Observation of the trainee with a client occurred during this supervisory period with a frequency appropriate for this experience type;
- ▶ The trainee was supervised for the required amount of time for this supervisory period;
- ▶ We have read and understand the most relevant version of the [Experience Standards](#);
- ▶ We are only including appropriate behavior-analytic activities in our totals listed above; and
- ▶ The experience hours obtained during this supervisory period are otherwise compliant with the [Experience Standards](#).

Supervisor Signature: _____ Date: _____

Trainee Signature: _____ Date: _____

This document must bear the signature (see the [Acceptable Signatures Policy](#)) of the responsible supervisor and trainee and must be signed by the last day of the calendar month following the month of supervision.

SUPERVISOR AND TRAINEE MUST EACH RETAIN A COPY OF THIS FORM FOR AT LEAST 7 YEARS.

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