



**Section II: Supervisor's Certification**

A limited permit may be issued to an applicant who has met all requirements for licensure except the licensing examination and/or experience requirements. The permit is valid for two years and may be extended, at the discretion of the Department, for up to two additional one-year periods.

**The applicant named in Section I is seeking a limited permit to practice as a Creative Arts Therapist in New York State. Complete the information below to certify that the applicant will be supervised at the setting named below. Supervision and practice under a limited permit must be consistent with the requirements for supervised experience in Appendix A. You must also attach a copy of your license as well as a copy of the operating certificate or certificate of incorporation authorizing the proposed setting to employ licensed professionals and provide services that are restricted under Title VIII of the Education Law.**

Applicant's name: \_\_\_\_\_  
(Section I, item 4)

**A.** I have reviewed Appendix A and I meet the qualifications as a supervisor.

I am a licensed \_\_\_\_\_ in \_\_\_\_\_  
Professional Title State

License number (Attach a copy of your license if other than New York) \_\_\_\_\_ Date licensed \_\_\_\_\_

**B.** Setting where experience will take place:

\_\_\_\_\_  
Name of facility (if applicable)

\_\_\_\_\_  
Street City State Zip Code

The above facility is a (check one and attach a copy of the operating certificate):

- Office of Mental Health (OMH) approved facility
- Office for People With Developmental Disabilities (OPWDD) approved facility
- Office of Alcoholism and Substance Abuse Services (OASAS) approved facility
- Department of Health (DOH) approved hospital or nursing home
- Office of Children & Family Services (OCFS) approved facility
- Public health agency or facility approved by the social services district
- Office of a licensed Creative Arts Therapist (not owned by the applicant)
- Office of a licensed physician, clinical social worker, or psychologist (PLLP, PLLC)
- Other facility: \_\_\_\_\_

**Attestation of Supervisor**

I will supervise the permit holder in accordance with the requirements in Appendix A. I declare that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in or in connection with this certification may be the cause for denial of permit and licensure.

Supervisor's signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print full name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services,  
PO Box 22063, Albany, NY 12201.**