



**Section II: Verification of Experience (Continued) - To be completed by the Clinical Supervisor**

**Certification**

I certify that the information provided in Section II of this form is complete and accurate to the best of my knowledge and that I have personally supervised the person named in this form in the performance of the competencies listed above.

Clinical Supervisor signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

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

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

New York State license number: 

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Profession: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services,  
Clinical Nurse Specialist Unit, 89 Washington Avenue, Albany, NY 12234-1000.**