

## Creative Arts Therapist Form 4B Certification of Supervised Experience

### Applicant Instructions

Assigned Number (from Form 4): \_\_\_\_\_

1. Complete Section I. Be sure to sign and date item 9.
2. Send the entire form and a copy of Appendix A to the supervisor who will certify your experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

### Section I: Applicant Information

1. Last 4 Digits of Social Security Number \_\_\_\_\_  
*(Leave this blank if you do not have a U.S. Social Security Number)*
2. Birth Date    Month    Day    Year
3. Print Name    Last  
                            First  
                            Middle
5. Telephone/Email Address  
Daytime Phone  
 Home or  Business

**Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.**

4. Mailing Address  Home or  Business  
(You must notify the Department within 30 days of any address or name changes)  
Line 1 \_\_\_\_\_  
Line 2 \_\_\_\_\_  
Line 3 \_\_\_\_\_  
City \_\_\_\_\_  
State                      ZIP Code \_\_\_\_\_  
Country/  
Province \_\_\_\_\_
6. New York State DMV ID Number  
(Driver or Non-Driver ID)  
  
*(Leave this blank if you do not have a New York State DMV ID Number)*

7. Name as it appears on degree or other credentials (if different from above) \_\_\_\_\_

8. Name of supervisor \_\_\_\_\_ Assigned Number (from Form 4): \_\_\_\_\_

I practiced Creative Arts Therapy as defined below:

*“Creative Arts Therapy is the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts as approved by the Department; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate Creative Arts Therapy services.”*

Duration of supervised experience

Date beginning    \_\_\_\_\_    Date ending    \_\_\_\_\_  
                            mo.    day    yr.                      mo.    day    yr.

Total clock hours practicing Creative Arts Therapy \_\_\_\_\_

9. I request and give my permission to the individual listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

## Section II: Certification of Supervised Experience

**Instructions to the Supervisor:** Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant. If the supervised experience occurred outside of New York State, you must include a copy of your license and an operating certificate or authorization for the entity to provide professional services.**

Name of the applicant \_\_\_\_\_  
(see Section I, item 3)

I am a licensed \_\_\_\_\_ in \_\_\_\_\_  
Professional title Jurisdiction

License number (attach a copy of your license if other than New York State) \_\_\_\_\_ Date licensed \_\_\_\_\_ mo. \_\_\_\_\_ day \_\_\_\_\_ yr.

I am attesting that I supervised the above named applicant for at least one hour per week or two hours every other week in the practice of creative arts therapy (defined below):

*"Creative Arts Therapy is the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts as approved by the Department; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate Creative Arts Therapy services."*

Dates of experience From \_\_\_\_\_ To \_\_\_\_\_  Present  
mo. day yr. mo. day yr.

Total hours practicing Creative Arts Therapy \_\_\_\_\_

Identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ Creative Arts Therapists.

Agency/Practice Name \_\_\_\_\_

### Type of Setting (check one)

- Private practice owned by supervisor
- Professional entity (PLLC, PLLP, P.C.) owned by qualified supervisor (attached consent from SED)
- Sole proprietorship or other entity authorized under law (attach certificate of incorporation)
- Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), Department of Health (DOH), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)
- Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)
- Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)
- Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)
- Other (describe) \_\_\_\_\_

Agency/Practice address \_\_\_\_\_

Agency/Practice Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Agency/Practice web site \_\_\_\_\_

The supervisor must be employed by the same agency as the applicant and have access to all patient files and records; have responsibility for the assessment, evaluation and treatment of each patient diagnosed and treated by the applicant practicing under his/her supervision; and each patient must consent to treatment by the supervised applicant.

Signature of agency representative \_\_\_\_\_ Date \_\_\_\_\_

### Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise a LCAT applicant. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

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