# QABA Supervision Verification Form

## Individual Supervisor - QASP-S, CABA

**Date range of supervision** _____ **to** _____

**Please complete one form per experience:**

**Trainee Name** _____**Current credential/number if applicable** _____

**Name of Employer** _____

**Supervisor Name:** _____**Supervisor Credential & Number** _____

**Name of Employer:** _____

**Experience Hours: (Supervision must be in-person for minimum of 1 hour every 3 months. Attach variance if applicable.)**

**A. Total completed hours (supervisor not present):** _____

**B. Rate of supervision required:** _____ **(5% ABAT or QASP-S < 500 hours or CABA; 2% QASP-S > 500 hours)**

**C. Number of hours required supervision for this period (A x B)** _____

**D. Total supervised hours:** _____ **(as documented on supervisor log)**

**E. Number of hours met with supervisor in person:** ____ **Supervised via HIPAA-approved video:** ____

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**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;
- We are only including appropriate behavior-analytic activities in our totals listed above;
- The experience hours obtained during this supervisory period are compliant with HIPAA standards.

Supervisor Signature: _____ Date: _____

Trainee Signature: _____ Date: _____

This document must bear the signature of the 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.**