College of
HEALTH AND CARE
PROFESSIONALS OF BC

CERTIFICATION PROGRAMS

# SUPERVISION DECLARATION

*This form must be completed by each certification program supervisor.*
*Please review the supervision information on the **Certified Practices page**.*

## Supervisor information

Supervisor name _____ Licence # _____

Healthcare professional designation if not a CHCPBC licensee
(must be authorized to practice the restricted activity) _____

Certification program (Select one) _____

Name of supervised licensee _____

Certification program start date _____ End date _____

## Supervisor declaration

☐ I acknowledge that I am a health professional licensed in good standing and authorized to practice the restricted activity I supervised under the *Health Professions and Occupations Act*'s regulations.

☐ I reviewed the eligibility criteria and certification program requirements to supervise the licensee named above.

☐ I confirm that the licensee successfully completed all certification program requirements by demonstrating the knowledge, skills, and clinical judgment necessary to perform the certified restricted activity autonomously, ethically, competently, and safely.

☐ I certify and declare that the information provided in this document is true.

Signature _____ Date _____

Email or phone _____