Certified Behavioral Health Case Manager Supervisor
Work Experience Verification Form

DIRECTIONS

This form allows for one employer to document work hours as required for the CBHCMS credential. Provide a separate form to each employer who will document experience for certification purposes.

All information must be TYPED. Handwritten forms will be denied. This is a two-part form.

- Part One is completed by the applicant and provided to the employer.
- Part Two is completed by the employer and provided to FCB by mail, email or fax (see below).

Upon completion, please submit the form and supporting documentation directly to the FCB. *Work Experience Verification Forms* will not be accepted from the applicant.

Mail: Florida Certification Board
Attn: Certification Operations
1715 South Gadsden Street
Tallahassee FL 32301

Email: Certification Specialist's email or admin_assist@flcertificationboard.org
Fax: 850-222-6247
Subject Line: Work Experience Verification (applicant name)

REQUIREMENT

CBHCMS Description	A designation is for individuals who supervise those who provide direct targeted case management services to adults and/or children with mental health conditions, substance use disorders, and/or those involved in the child welfare system who require behavioral health case management services.
Related Work Experience Requirement	Work experience is prorated depending on the applicant's highest level of formal education. • 8,000 hours – Bachelor's Degree or non-related Master's Degree or higher • 4,000 hours – Master's Degree or higher in a related field Volunteer experience and non-clinical internships are not eligible for certification purposes. Eligible work experience occurred within the last 10 years.
Supporting Documentation	Attach a position description that directly relates to the core competencies of the credential. Must be on agency letterhead.

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All information must be typed. Handwritten forms will be denied.

Part 1: To be completed by the applicant prior to providing to employer for completion.

Applicant Information: Please list the position you held for which you are requesting credit for certification and verification by your employer. Report employment dates in the following format: MM/DD/YYYY to MM/DD/YYYY. Use a separate form for each position/employer documenting work experience.
Applicant Name:
Employer:
Type of Position: Full-Time Part-Time
Position Title:
Immediate Supervisor:

Part 2: To be completed by the employer's personnel officer or designee only.

Section A: Verifier's Contact Information	
Last Name:	**First Name:**
Title:	**Employer:**
Email Address:	**Business Phone:**
Work Address:	
City:	**State:**
Zip Code:	**County:**

Section B: Experience Attestation	
I have read and understand the on-the-job experience requirements for Certified Behavioral Health Case Manager Supervisor (CBHCMS) certification. The following information can be verified by employment records maintained by the agency. I consent to an audit of such records if requested. Yes No	
Applicant's Position Description Attached: Yes	Type of Position: Full-Time Part-Time
Applicant's Employment Dates (use MM/DD/YYYY format): From: To:	
Average number of hours per week providing related services:	
By my signature, I attest that the above material is true to the best of my knowledge	
Verifier's Signature *(FCB accepts manual and electronic signatures)* **Date**	