

STEVE SISOLAK
Governor



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Director

DENA SCHMIDT
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
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Licensed Assistant Behavior Analyst Supervisor Qualification Form

USE TYPEWRITER OR PRINT LEGIBLY IN INK

1.00 SUPERVISOR PERSONAL DATA		1.01 Date	1.02 Name of Assistant Behavior Analyst		
1.03 Last Name, First Name, Middle Initial		1.04 Identified Gender	1.05 Social Security #		
1.06 Home Address-Street	1.07 City	1.08 State	1.09 Zip	1.10 Phone ()	
1.11 Business Address-Street	1.12 City	1.13 State	1.14 Zip	1.15 Phone ()	
2.00 LICENSE INFORMATION					
2.01 Nevada license #:		2.02 Date License Granted:			
2.03 BCAB Certification #:		2.04 Date Certified:			
3.00 DESCRIPTION OF QUALIFYING SUPERVISION TRAINING OR EXPERIENCE (see NAC 641.1563)					

I affirm, under penalty of perjury, that all the information supplied herein is to the best of my knowledge true, accurate and complete and that I have not withheld, misrepresented, or falsely stated any information relevant to my training and experience or my fitness to serve as a supervisor.

Signature of Supervisor

Date