

**International Association of Eating Disorders Professionals**  
**PO Box 1295 / Pekin, IL 61555-1295**  
**Tel. (309) 346-3341 / (800) 800-8126 / Fax (309) 346-2874**  
**Email: info@iaedp.com / Website: www.iaedp.com**

**APPENDIX D2: Approved Supervisor's Documentation Form**

**I. SUPERVISOR INFORMATION**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

**II. APPLICANT INFORMATION**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

**III. INSTRUCTIONS**

Dear Supervisor: The above named applicant has named you as someone who can document his/her supervised internship or work experience, as partial fulfillment of the requirements for certification as an Eating Disorders Specialist, Associate or Intern. Please complete the form as accurately and completely as possible, and mail it to the Association, or give it to the applicant for forwarding to the Association (if you wish the applicant to have access to it).

**IV. CONFIDENTIALITY STATEMENT**

The information contained in this document is confidential. It may be released upon request by the individual to whom it pertains; however, it will not be released to the general public. Supervisors are urged to be candid and forthright in their evaluations of the applicant inasmuch as supervised professional experience must be completed in a manner satisfactory to the Association.

**V. VERIFICATION OF EXPERIENCE**

A. List the place or places where the experience under supervision occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SUBMIT IN QUADRUPPLICATE**

B. List titles, degrees, licenses and certificates you held during the supervision of the applicant:

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C. What were the applicant's title and professional identity while under your supervision?

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D. If the applicant was in a training program while under supervision, describe the program and give Dates (from when to when):

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E. Describe the nature of your relationship with the applicant (employer, teacher, supervising as part of your prescribed job duties, etc. state whether applicant paid for the supervision);

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F. Describe the duties the applicant performed under your supervision, including specific duties and Percentage of supervised work spent in each activity:

<b>Duty or Function</b>	<b>Describe</b>	<b>Percentage of Time Spent in that Duty</b>
<hr/>		
<hr/>		
<hr/>		
<b>Total (should equal 100%)</b>		<hr/>

G. List the total numbers of hours worked under your supervision, specifically in eating disorders (as distinct from chemical dependency, general mental health, etc.):

FROM (month/day/year) \_\_\_\_\_ TO(month/day/year)\_\_\_\_\_

# hours per week \_\_\_\_\_ # of weeks \_\_\_\_\_ Total # Hours \_\_\_\_\_

H. Breakdown of types and amounts of supervision:

<b>Types of Supervision</b>	<b>Supervisor Responsible</b>	<b>Hours Per Week</b>
Individual	_____	_____
Group (# of persons in groups)	_____	_____
Other (specify)	_____	_____

**VI. RATING OF APPLICANT'S PERFORMANCE**

A. Overall Rating:

- Superior
- Acceptable
- Unacceptable

B. List strengths and weaknesses:

Strengths: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

C. Remarks: (Is applicant's work in your judgment of sufficient quality to justify certification As an Eating Disorders Specialist, Associate or Intern? List any reasons why applicant Should not be certified; etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VII. AUTHORIZING SIGNATURE**

I declare under penalty of perjury that the foregoing is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date