

**SUPERVISORY DISCLOSURE**

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number (MRN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that Easterseals is dedicated to maintaining exceptional services and thus requires initial and on-going associate training which involves supervision from more experienced and/or licensed providers. As such, your assessment will be completed by an unlicensed, doctoral level clinician in training, *Name, Credentials*. *They* will be working under the guidance and supervision of an Easterseals’ Licensed Clinical Psychologist, Dr. *Name* (PsyD #). Both the trainee and supervisor will maintain confidentiality in accordance with Easterseals’ privacy policy and state and federal privacy regulations. Feel free to discuss questions or concerns with your assessor directly and contact Dr. *Name* at *Number* or *Name*@essc.org as necessary.

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Participant Signature Date

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

Parent/Guardian Signature Date