Must be completed if you are Health Professional

SUPERVISING Autism Specialist

AS THE SUPERVISING Autism Specialist FOR:

_____ (insert name of applicant), I can attest that I supervise all plans of treatment as required by law, and he/she is providing care for Cenpatico members solely at the following location(s),

_____

_____

_____

Location(S) of Practice

DATE_____

Signature of Supervising Autism Specialist: _____

_____

Print Supervising Autism Specialist's Name