STATE OF CALIFORNIA

COMPLEMENTARY AND ALTERNATIVE MEDICINES VERIFICATION FORM



CAM VER FORM (Rev. 05/2022)

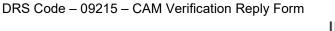
CalVCB Application No.: _	
Can v CD / Application 1 11011 =	

Instructions: A statement from the crime victim's medical or mental health treatment provider is required when requesting Complementary and Alternative Medicines (CAM) beyond the first five (5) sessions. Some provider types require a supervisor signature*. See victims.ca.gov for more information.

Victim Information		
Name:	Phone Number:	
Address:		
City:		
Crime Information		
Crime Date:	Type of Crime:	
Is it necessary for the victim to receive CA qualifying crime? No Yes Not enough is Explain why CAM treatment is necessary for the victim to receive CA qualifying crime?	nformation to determine	e.
Number of CAM sessions recommended beyont to exceed 20 total sessions):		

CALIFORNIA VICTIM COMPENSATION BOARD

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CAM treatment recommended:	
Acupuncture/Chinese Medicine Biofeedback	Chiropractic Tx
Holistic Medicine Hypnotherapy Mas	ssage Therapy Music Therapy
Naturopathic Medicine Other	
Medical or Mental Health Provider Information	
Medical or Mental Health Provider:	Phone Number:
Business Address:	
City: State:	Zip:
License Number and Type:	Expiration Date:
I further certify that I am licensed to practice in the state of:	
Signature:	Date:
*Supervised Nurse Practitioners and Physician As	sistants
Require a supervising physician's signature.	
Supervising Physician:	Phone Number:
	Thore Hamber:
License Number and Type:	
License Number and Type: I further certify that I am licensed to practice in the state of:	Expiration Date:
	Expiration Date:
I further certify that I am licensed to practice in the state of:	Expiration Date:
I further certify that I am licensed to practice in the state of: Signature:	Expiration Date: Date: Social Worker, Professional Clinical
I further certify that I am licensed to practice in the state of: Signature: *Supervised Mental Health Providers Psychology Intern, Psychological Assistant, Associate Counselor Intern, Marriage and Family Therapist Intern	Expiration Date: Date: Social Worker, Professional Clinical Sexual Assault Counselor requires a
I further certify that I am licensed to practice in the state of: Signature: *Supervised Mental Health Providers Psychology Intern, Psychological Assistant, Associate Counselor Intern, Marriage and Family Therapist Intern licensed supervising therapist signature.	Expiration Date: Date: Social Worker, Professional Clinical, Sexual Assault Counselor requires a Phone Number:
I further certify that I am licensed to practice in the state of: Signature: *Supervised Mental Health Providers Psychology Intern, Psychological Assistant, Associate Counselor Intern, Marriage and Family Therapist Intern licensed supervising therapist signature. Licensed MH Supervisor: Licensed MH Supervisor:	Expiration Date: Date: Social Worker, Professional Clinical, Sexual Assault Counselor requires a Phone Number: Expiration Date:

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