STATE OF CALIFORNIA

COMPLEMENTARY AND ALTERNATIVE MEDICINES VERIFICATION FORM

CAM VER FORM (Rev. 05/2022)

CalVCB Application No.: _____

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: _____ State: _____ Zip: _____

Crime Information

Crime Date: _____ Type of Crime: _____

Is it necessary for the victim to receive CAM treatment due to injuries directly related to the qualifying crime?

☐ No. ☐ Yes. ☐ Not enough information to determine.

Explain why CAM treatment is necessary for the victim's physical or emotional injuries?

_____

_____

_____

_____

Number of CAM sessions recommended beyond the first five sessions
(not to exceed 20 total sessions): _____

CAM treatment recommended:

☐ Acupuncture/Chinese Medicine ☐ Biofeedback ☐ Chiropractic Tx

☐ Holistic Medicine ☐ Hypnotherapy ☐ Massage 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 Assistants

Require a supervising physician's signature.

Supervising Physician: _____ Phone Number: _____

License Number and Type: _____ Expiration Date: _____

I further certify that I am licensed to practice in the state of: _____

Signature: _____ Date: _____

*Supervised Mental Health Providers

Psychology Intern, Psychological Assistant, Associate Social Worker, Professional Clinical Counselor Intern, Marriage and Family Therapist Intern, Sexual Assault Counselor requires a licensed supervising therapist signature.

Licensed MH Supervisor: _____ Phone Number: _____

License Number and Type: _____ Expiration Date: _____

I further certify that I am licensed to practice in the state of: _____

Signature: _____ Date: _____