UNIVERSAL LIFE CARE PLANNER CERTIFICATION BOARD

Certified Health Professional Life Care Planner Certification (CHLCP™)
Portfolio Examination

VERIFICATION OF WORK EXPERIENCE

Candidate's Name:_____

Candidate's Address:_____

As the above candidate's immediate supervisor or Human Resources Director, I verify that to the best of my knowledge that the above-named candidate has at least two years of life care planning experience within the past five years

Supervisor Name (please print)_____

Title:_____

Supervisor Signature:_____

Institution/Organization:_____

Address:_____

City/State/Zip code:_____

Supervisor Name (please print)_____

Title:_____

Supervisor Signature:_____

Institution/Organization:_____

Address:_____

City/State/Zip code:_____

P.O. Box 3311· Concord, NH 03302-3311