

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: \_\_\_\_\_