BBSM COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA

STANDARD TRACK ATTESTATION STATEMENT

This page is required for Standard Track candidates to verify completion of an SBSM-accredited Cognitive Behavioral Therapy for Insomnia training program.

Candidate's Name: ____

Program/Training Director's Name and Degree(s): ____

Area of Practice or Specialty: ____

BBSM Training Program: ____

Institution: ____

Address: ____

Training Program Start/Completion Dates: _______________________

I, the candidate's training/program director, hereby verify that the candidate has satisfactorily completed the above SBSM-accredited cognitive behavioral therapy for insomnia training program as part of the requirements to sit for the BBSM Cognitive Behavioral Therapy for Insomnia Examination.

_____________________________________ ______________

Training/Program Director Signature **Date**