



Board for
Certification of
Nutrition
Specialists

CNS Supervisor Report To be completed by the Supervisor

Part I: General Information

Date Submitted to BCNS

1. Name of Candidate Supervised
2. Candidate's title
3. Candidate's job description
4. Supervisor's Name
5. Supervisor's Email
6. Supervisor's Phone

I only supervise(d) work with clients* residing in states in which I am legally authorized to practice MNT.

I assume full legal responsibility for the work of my candidate(s) by overseeing, directing, and authorizing their work.

I have professional liability (or other) insurance.

I was reasonably available, appropriate to the circumstance, to my candidate when they were working with a client.

I am not married to, related to, or domestic partners with any of my candidates.

*Clients include those with whom you and your candidate(s) work.

Part II: Supervised Practice Experience Detail

1. Candidate worked under your supervision from: start date _____ to end date _____
2. How did you hold meetings with your candidate?

One-on-one

Group

Combination of one-on-one and group

3. Please provide the following detail for **monthly** meetings with this candidate (2 monthly meetings = approximately 2 hours)

No. of monthly hours for one-on-one meetings: ____

No. of monthly hours for group meetings: ____

Total no. of monthly hours: ____

NOTE: These meeting hours pertain to how much time the supervisor and candidate spend reviewing cases together.

4. What percentage of the supervised hours is spent on clinical work with clients (including any research for a specific case)? ____
5. What percentage of the supervised hours is spent on didactic learning (ie. group discussions, handouts, teaching presentations, practice management, etc.)? ____
6. What percentage of the supervised hours is spent on other work not related to client clinical care (such as research for presentations to market a practice)?

Check all that apply & add approximate percentage of time spent:

____ One-on-one clinical ____%

____ Research ____%

____ Food systems planning ____%

____ Group clinical ____%

____ Educational programs and materials ____%

____ Enteral/parenteral ____%

____ Other ____% explain:

7. In addition to general oversight of candidates' work with clients, are there other specific aspects of client care or professional practice you cover in your Supervised Practice Experience?

8. Describe the supervised practice experience setting (may check more than one):

____ Internship, residency, clinical rotation

____ Clinical practice

____ Community setting

____ Institution (hospital, nursing home, etc.)

____ Home health care

____ Other - please describe

9. Name and location of facility where candidate practiced during your supervision

Name:

Location:

10. Supervision completed:

___ In person / onsite

___ Remotely

___ Combination of in person and remotely

Part III: Supervised Practice Experience Evaluation

Please answer every question, using extra pages if needed.

1. Describe the nature of the supervised practice experience including such areas as: client demographics, range of health conditions, any area of specialization, etc.
2. Based on the competencies, what are your candidate's areas of strength?
3. Based on the competencies, what area(s) would additional training and experience enhance their job performance?
4. Describe the professional growth in your candidate as they progressed from beginner to intermediate practice stages. Is the candidate ready to practice on their own?
5. What is your candidate's most impressive attribute(s) that help them to successfully perform the job?
6. What was a difficult part of the job for your candidate and how did they overcome the obstacles?
7. What were the goals for the practice experience for this candidate? Explain how the goals were met.

Part IV: Supervised Practice Experience Ratings

Please rate the candidate's performance in each competency achieved under your supervision. All competencies under each category may not have been covered under your supervision.

E= Exceeds requirements

M = Meets requirements

N = Needs improvement

NA = Not addressed (under my supervision)

D = Does not meet

ANA's DEFINITION of MNT: *Medical Nutrition Therapy is the provision of nutrition care services for the purpose of managing or treating a diagnosed medical condition.*

Category A: Personalized Nutrition Assessment & Interpretation

Competency	Rating	Explanation
Conduct client-appropriate health history		
Conduct diet and lifestyle history		
Conduct biochemical and laboratory assessment		
Conduct anthropometric evaluation		
Assess impact of diet on health status		
Identify clinical status		
Understand impact of genetic / genomic factors		

Category B: Personalized Nutrition Intervention, Education, Counseling, or Management

Competency	Rating	Explanation
Formulate applicable dietary and nutraceutical		

interventions for prevention, modulation, and management of chronic systemic disorders		
Identify drug-nutrient / drug-herb interactions		
Understand interactions between nutrients		
Apply basic principles of dietary therapeutics and behavior optimization		
Understand basic principles of nutraceutical and supplement therapeutics		
Be familiar with eating behavior and eating disorders		
Assess individual patient data and compare with other data to develop therapeutic interventions		
Be familiar with effects of, and safe use of, common botanical supplements		
Have working knowledge of food quality and safety issues		
Be familiar with cultural issues, ethical standards, and boundaries		
Apply knowledge of epidemiology and biostatistics in development of evidence-based treatment plans		

Category C: Nutrition Monitoring or Evaluation

Competency	Rating	Explanation
Ongoing monitoring and evaluation		

General Competencies

Competency	Rating	Explanation
Demonstrate ability to work as part of inter-professional team		
Demonstrate effective oral & written communication skills		
Effectively document client interactions and maintain client records		

Overall Performance (Rating & Explanation)

Overall Performance	Rating	Explanation

___ I have used the PN Case Data Collection form as a tool to review all work I have supervised with this candidate

___ I have attended an ANA PN SPE training session

___ I have approved one final comprehensive Personalized Nutrition (PN) Case Report

___ I have signed off on the candidate's SPE Hours Tracking Tool

___ I attest the candidate named herein has completed the work stated in this report

Signature:

Date:

Please save and send to Applications@NutritionSpecialists.org.