



Complementary and Alternative Medicines Verification Form

CalVCP 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 <http://calvcp.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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:

<input type="checkbox"/> Acupuncture/Chinese Medicine	<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Holistic Medicine
<input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Music Therapy	<input type="checkbox"/> Naturopathic Medicine
<input type="checkbox"/> Other:			

Medical or Mental Health Provider Information

Medical or Mental Health Provider:	Phone Number:
Business Address:	
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:** Requires 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:

***Supervised Mental Health Providers:** Psychology Intern, Psychological Assistant, Associate Social Worker, Professional Clinical Counselor Intern, Marriage and Family Therapist Intern, Sexual Assault or Domestic Violence Peer 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:



Privacy Notice on Collection

1. VCGCB collects this information based on California Government Code sections 13952 et seq. and 13954.
2. All information collected from this site is subject to, but not limited to, the Information Practices Act. See <http://vcgcb.ca.gov/media/pract.aspx>.
3. This information is collected for the purpose of determining eligibility for compensation.
4. VCGCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
 - a. Conform to the edicts of the law or comply with legal process served on VCGCB or the site;
 - b. Protect and defend the rights or property of VCGCB; and,
 - c. Act under exigent circumstances to protect the personal safety of users of VCGCB, or the public.
5. Individuals are to provide only the information requested.
6. The information provided is mandatory.
7. The consequences of not providing the requested information could result in the denial of your application.
8. You have the right to access the records containing the personal information that you provided.
9. The information collected is used by the California Victim Compensation Program.
10. Any questions regarding the information collected, please write to the following address: 400 R Street, 5th Floor Sacramento, CA 95811, email info@vcgcb.ca.gov, call (800) 777-9229, or contact the VCGCB Privacy Coordinator at InfoSecurityandPrivacy@vcgcb.ca.gov.
11. For additional information regarding privacy, please see VCGCB's Privacy Notice. See <http://vcgcb.ca.gov/privacy.aspx>.
12. For information regarding consumer information on security, please visit <https://oag.ca.gov/privacy/online-privacy>.