SUPERVISED VISITATION PROGRAM PROVIDERS
AFFIDAVIT OF COMPLIANCE

I, {*full legal name*} _____ being sworn, certify that I continue to meet all of the qualifications to be a supervised visitation program provider listed in chapter 753, Florida Statutes, and the Minimum Standards for Supervised Visitation Programs adopted by the Florida Supreme Court.

Full Name: (Print)		Program Name	
Business Address:		Email Address:	
		Phone:	

_____ _____
Signature Date

STATE OF FLORIDA
COUNTY OF _____

Sworn to or affirmed and signed before me on _____ by

_____.

_____
NOTARY PUBLIC
(Print, type, or stamp commissioned name of notary)

___ Personally known

___ Produced identification Type of identification produced: _____

Remit annually, no later than June 30th, to:
Director of Case Management
101 N. Alabama Ave., Suite B253
DeLand, FL 32724
or via email to: cpringle@circuit7.org