



STATE OF MAINE
 DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
 OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
 BOARD OF ALCOHOL & DRUG COUNSELORS
 76 NORTHERN AVENUE
 GARDINER, MAINE 04345

Janet T. Mills
 Governor

Anne L. Head
 Commissioner

SUPERVISION AGREEMENT FORM

The CCS is responsible for notifying the Board when the applicant/licensee is no longer under the supervision of CCS. Failure to notify the Board constitutes a violation of Board Rule.

CLINICAL SUPERVISION INFORMATION <i>(TO BE COMPLETED <u>IN FULL</u> BY THE SUPERVISOR)</i>	
Name of Prospective/Current Licensee:	License Number:
Licensee Email Address:	Initial Issue Date:
Name of Clinical Supervisor:	Supervisor License Number:
Supervisor Email Address:	Initial Issue Date:
Name of Agency:	Agency License Number:
Agency Telephone:	Agency License Expiration:
Agency Address:	
City:	State:
	Zip Code:

My signature attests to the present employment of the applicant/licensee named above as an Alcohol & Drug Counseling Aide (“ADCA”) and that the requirements of the position conform to the Board’s definition of an ADCA (please refer to 32 MRS § 6203-A (2) for more information). I agree to notify the Board when the above named licensee is no longer under my supervision.

 Signature of Certified Clinical Supervisor

Date: _____