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

SUPERVISOR'S AFFIDAVIT

Use a separate form for each supervisor verifying experience and for each employment setting.

Clinically Supervised Work Experience Information *(To be completed in full by supervisor)*	
Name of 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 Telephone:
Agency Mailing Address: City: State: Zip Code:	

Clinically supervised work experience must be obtained while both licensee and supervisor held active licenses:	
Period of licensed clinically supervised experience:	From: _____ (month/day/year) To: _____ (month/day/year)
Total number of hours of licensed clinically supervised practice of alcohol and drug counseling accrued during the period listed above:	
Did work experience encompassed all 12 core functions as defined by the Board?	☐ Yes ☐ No

Did you provide supervision to the above licensee during the period indicated on this form?

☐ Yes ☐ No

If no, please provide additional documentation describing your relationship with the applicant.

I attest that the information provided on this form is verifiable, factual, and accurate to the best of my knowledge. I agree to return this form to the licensee for submission to the Board of Alcohol & Drug Counselors.

_____ Date: _____

Signature of Certified Clinical Supervisor