STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8623 – FAX:(207)624-8637

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's Job Title:		Telephone #:

The following section is to be completed by employer or supervisor only

Name of Agency: _____

Address: _____

Clinically supervised work experience must be <u>obtained while licensed</u>. Please include the applicant's valid license type and number.

Dates worked to obtain hours while licensed (mm/yyyy)	Applicant's License Type	Applicant's License Number	Work area of practice that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE (Continued)

Dates worked to obtain hours while licensed (mm/yyyy)	Applicant's License Type	Applicant's License Number	Type of Work Experience that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:				

Did you personally supervise the above named applicant during the timeframe indicated on this form? ☐ **Yes** ☐ **No**

If no, describe your relationship with the applicant and include name and license number of Certified Clinical Supervisor: _____

_____

I, the _____ of the above named applicant, certify that the information provided on this form is verifiable, factual and accurate.
(i.e. supervisor, human resources, etc)

Print Name: _____ License #: _____

Title: _____

Signature: _____ Date: _____

TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the applicant; not the Board.