



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)624-8674 – 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 obtained while licensed. Please include the applicant's valid license type and number.**

Date of employment/ Dates worked to obtain hours (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: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	

**VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE  
(Continued)**

Date of employment/ Dates worked to obtain hours (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: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
<b>TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:</b>				

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 (i.e. supervisor, human resources, etc) provided on this form is verifiable, factual and accurate.

Print Name: \_\_\_\_\_ License #: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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