CLINICALLY SUPERVISED EXPERIENCE FOR RECERTICATION OF CADC I

COUNSELOR'S NAME____

SUPERVISOR'S NAME____

AGENCY____

PROFESSIONAL LICENSES AND/OR CERTIFICATES YOU HOLD_____________

Purpose: This is to document that the counselor has received clinical supervision directly relating to the 12 Core Functions. Methods of clinical supervision that will be accepted are activities designed to provide training, review, education and/or processing counseling activities. These activities are monitored and documented by the clinical supervisor, who provides timely feedback to assist the counselor in this learning process.

Supervisors:

- Supervisors should have a good clinical background in substance abuse, chemical dependencies and co-occurring disorders.
- Acceptable credentials for clinical supervisors are CCS, CADCII, CCDP, CCDP-D, CAADC, CACII, MAC or any licensed behavioral health professional such as LPC, LCSW, LMFT, RN, PsyD. or Psychiatrist who have a minimum of 5 hours of Co-Occurring or Addiction specific continuing education hours per year; certification of attendance/ completion may be requested.

Counselors:

- Candidates must obtain a minimum of 20 hours of ***face to face clinical supervision*** in each recertification period.

This counselor has spent a total of __________ hours in direct, face-to face supervision with me

from: _____/_____/_____ to: _____/_____/_____ (Month/Day/Year)

Size of Counselor's caseload:

Individual counseling _____ Group counseling_____ Family counseling_____

I HEREBY CERTIFY THAT I HAVE OBSERVED AND HAVE FIRSTHAND KNOWLEDGE OF THIS APPLICANT'S WORK AND THAT THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE, TRUE

____

Supervisor's Signature **Certification/License Number** **Date**

PLEASE RETURN DIRECTLY TO:

Alcohol and Drug Abuse Certification Board of Georgia, Inc.
P.O BOX 250449
Atlanta, GA 30325

Do not return this form to the applicant,
unless it has been placed in a sealed envelope with your signature across the back seal!

Revised 12/2017