

THE MASSACHUSETTS BOARD OF SUBSTANCE ABUSE
COUNSELOR CERTIFICATION, INC.

MBSACC

CLINICAL SUPERVISOR VERIFICATION FORM
FOR THE
CERTIFIED CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL

CONFIDENTIAL

TO BE COMPLETED BY APPLICANT -

APPLICANT'S NAME: _____ DATE: _____
(PLEASE PRINT)

I authorize the Massachusetts Board of Substance Abuse Counselor Certification to seek additional information about my work and counseling skills from the supervisor listed below:

PRINT NAME OF CLINICAL SUPERVISOR

APPLICANT'S SIGNATURE

I, hereby, waive my right to inspect this verification form and any subsequent information provided by the supervisor in connection with my application for certification.

APPLICANT'S SIGNATURE

To the Clinical Supervisor:

The individual named above is applying to MBSACC for Certification as a Certified Criminal Justice Addictions Professional (CCJP). You have been identified by the applicant as a clinical supervisor for part or all of his/her clinical work experience; therefore, the information requested from you is an essential part of the Board's evaluation of this applicant, and this completed form must be on file before the application can be reviewed and processed. Please confirm with the applicant the date by which this completed verification must be postmarked by you in order to meet the application deadline date requirement.

*The Board appreciates your accurate and truthful reporting. This form is considered by the Board to be confidential and will not be made available to the applicant. As Supervisor, you may wish to keep a photocopy of this Verification Form for your files, but you must **not** provide a copy of the completed form to the applicant nor allow him/her to view its contents. The applicant has waived his/her right to view the contents of this form. MBSACC reserves the right to request further information from you concerning this applicant, if necessary, and appreciates and thanks you for your cooperation.*

MBSACC

**PLEASE RETURN THE COMPLETED FORM DIRECTLY BACK TO US AT:
MBSACC, 560 LINCOLN ST, P.O. BOX 7070, WORCESTER, MA 01605**

WORK EXPERIENCE VERIFICATION

SUPERVISOR'S NAME (PLEASE PRINT)

SUPERVISOR'S JOB TITLE (PLEASE PRINT)

CURRENT AGENCY NAME & ADDRESS

() _____
AGENCY AREA CODE & PHONE NUMBER

HIGHEST DEGREE EARNED

PLEASE LIST ANY CERTIFICATIONS OR LICENSES YOU CURRENTLY HOLD AND THE STATE FROM WHICH THEY WERE ISSUED. IF THE CERTIFICATION OR LICENSE IS NATIONAL, PLEASE SO NOTE:

RELATIONSHIP TO APPLICANT (PLEASE CHECK ONE):

- CONSULTANT PRESENT SUPERVISOR
 PAST SUPERVISOR OTHER (PLEASE SPECIFY) _____

AGENCY WHERE SUPERVISION OCCURRED (LINE ABOVE & PLEASE INCLUDE ADDRESS)

EMPLOYMENT SETTING (CHECK ANY BOXES THAT APPLY):

A. INSTITUTIONAL SETTING

- CORRECTIONS, STATE INSTITUTIONAL (PRISONS)
 CORRECTIONS, COUNTY OR CITY INSTITUTIONAL (DETENTION FACILITIES)
 ADULT JUVENILE

B. COMMUNITY SETTING

- COMMUNITY CORRECTIONS (Probation/Parole/Supervision Agencies)
 ADULT JUVENILE
 COURT MANDATED (Drug Court, Pretrial/Diversion)
 ADULT JUVENILE

C. TREATMENT SETTING

- ADULT JUVENILE

D. OTHER (PLEASE SPECIFY) _____

SUPERVISOR'S JOB TITLE @ TIME OF SUPERVISION

APPLICANT'S JOB TITLE @ TIME OF SUPERVISION

APPLICANT'S POSITION (PLEASE CHECK ONE):

- FULL TIME PART TIME INTERNSHIP/PRACTICUM
 OTHER (PLEASE SPECIFY) _____

WORK EXPERIENCE VERIFICATION (Cont'd.)

APPLICANT'S DATES OF EMPLOYMENT IN CRIMINAL JUSTICE/ADDICTIONS

_____ TO _____
MONTH/YEAR MONTH/YEAR

NUMBER OF HOURS APPLICANT WORKED WEEKLY: _____

NUMBER OF HOURS PER WEEK APPLICANT WORKED SPECIFICALLY PROVIDING
CRIMINAL JUSTICE/ADDICTIONS SERVICES: _____

NUMBER OF SUBSTANCE ABUSE COUNSELING HOURS PER WEEK SPENT IN THE FOLLOWING
AREAS (Do not include hours that are not specifically spent in counseling such as staff meetings,
report/record keeping, trainings, etc.):

INDIVIDUAL COUNSELING: _____ GROUP COUNSELING: _____

SUPERVISION OF APPLICANT'S WORK OCCURRED FROM:

_____ TO _____
MONTH/YEAR MONTH/YEAR

NUMBER OF HOURS OF DIRECT (FACE-TO-FACE) SUPERVISION PER WEEK FOR PERIOD LISTED
ABOVE: _____

IN THE SPACE BELOW, PLEASE PROVIDE A DETAILED DESCRIPTION OF THE APPLICANT'S
PRIMARY JOB RESPONSIBILITIES IN CRIMINAL JUSTICE/ADDICTIONS AT THE TIME OF
SUPERVISION:

REFERRING TO THE CRIMINAL JUSTICE DOMAINS LISTED BELOW, PLEASE CHECK THOSE WHICH
DIRECTLY RELATE TO THE APPLICANT'S POSITION:

- | | |
|--|--|
| <input type="checkbox"/> DYNAMICS OF ADDICTIONS AND CRIMINAL BEHAVIOR | <input type="checkbox"/> SCREENING, INTAKE, AND ASSESSMENT |
| <input type="checkbox"/> LEGAL, ETHICAL, AND PROFESSIONAL RESPONSIBILITY | <input type="checkbox"/> CASE MANAGEMENT, MONITORING, AND CLIENT SUPERVISION |
| <input type="checkbox"/> CRIMINAL JUSTICE SYSTEM AND PROCESSES | <input type="checkbox"/> COUNSELING |

WORK EXPERIENCE VERIFICATION (Cont'd.)

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE APPLICANT:

COMMENTS AND/OR ADDITIONAL INFORMATION YOU FEEL MAY BE PERTINENT:

ICERTIFY THAT I WAS EMPLOYED BY THE AGENCY NOTED BELOW AS A SUPERVISOR OF THE APPLICANT NOTED BELOW AND WAS, THEREFORE, IN A POSITION TO DIRECTLY OBSERVE THE APPLICANT'S WORK AT THAT AGENCY.

AGENCY NAME (PLEASE PRINT)

APPLICANT'S NAME (PLEASE PRINT)

SUPERVISOR'S SIGNATURE

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES (PLEASE CHECK **ONLY** ONE)

- I RECOMMEND THIS APPLICANT FOR CERTIFICATION
- I HAVE SOME RESERVATIONS ABOUT RECOMMENDING THIS APPLICANT FOR CERTIFICATION
(PLEASE SPECIFY BRIEFLY ON A SEPARATE SHEET OF PAPER)
- I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION
(PLEASE SPECIFY BRIEFLY ON A SEPARATE SHEET OF PAPER)

IATTEST THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED IN THIS VERIFICATION FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SUPERVISOR'S NAME (PLEASE PRINT)

SUPERVISOR'S SIGNATURE

DATE

WORK EXPERIENCE VERIFICATION (Cont'd.)

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THE APPLICANT HAS WAIVED HIS/HER RIGHT TO VIEW ITS CONTENTS.

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MBSACC APPRECIATES AND THANKS YOU FOR YOUR COOPERATION