THE MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

CLINICAL SUPERVISOR VERIFICATION FORM

for the

CCDP & CCDP-D CERTIFICATION

CONFIDENTIAL

TO BE COMPLETED BY APPLICANT –

APPLICANT NAME: _____ DATE: _____
(PLEASE PRINT)

I authorize the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) 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

Dear Clinical Supervisor:

The individual named above is applying to MBSACC for Certification as a Certified Co-Occurring Disorders Professional (CCDP or CCDP-D). 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 the eligibility of this applicant. 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 form must be postmarked by you in order to meet the application deadline date requirement.

The Board appreciates your accurate and truthful reporting. This form will be 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** *supply a copy of the completed form to the applicant. The applicant has waived his/her right to view the contents of this form. MBSACC reserves the right to request further information from you, if necessary, concerning this applicant.*

MBSACC

PLEASE RETURN THIS FORM DIRECTLY BACK TO US AT:
MBSACC, 560 LINCOLN STREET, WORCESTER, MA 01605
WE APPRECIATE YOUR COOPERATION

PART A

(All Supervisors must complete Part A)

_____ _____

SUPERVISOR'S NAME SUPERVISOR'S CURRENT JOB TITLE

_____

CURRENT AGENCY NAME & ADDRESS

(_____)_____ _____

AGENCY PHONE NUMBER (Please include area code) HIGHEST DEGREE EARNED

PLEASE LIST ANY CERTIFICATIONS OR LICENSES YOU CURRENTLY HOLD AND THE STATE(S) 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 (Specify) _____

PART B

(Part B is <u>only</u> for verifying the applicant's employment providing integrated services to clients with co-occurring mental health and substance abuse disorders. Complete this section if applicable.)

_____

NAME OF AGENCY WHERE SUPERVISION OCCURRED (PLEASE INCLUDE ADDRESS)

_____ _____

SUPERVISOR'S JOB TITLE AT TIME OF SUPERVISION APPLICANT'S JOB TITLE AT TIME OF SUPERVISION

APPLICANT'S DATES OF EMPLOYMENT PROVIDING INTEGRATED SERVICES TO CLIENTS WITH CO-OCCURRING DISORDERS:

From: _____/_____/_____ To: _____/_____/_____

Month Day Year *Month Day Year*

AVERAGE NUMBER OF HOURS APPLICANT WORKED PER WEEK: _____

TOTAL NUMBER OF HOURS PER WEEK SPENT IN DIRECT COUNSELING TO CLIENTS WITH CO-OCCURRING DISORDERS: _____

NUMBER OF HOURS OF COUNSELING PROVIDED IN THE FOLLOWING AREAS:

INDIVIDUAL COUNSELING _____ GROUP COUNSELING _____

PART B (CONT'D.)

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 AT THE TIME OF SUPERVISION.

_____

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PART C

(Part C is only for verifying the applicant's employment providing counseling services to clients with either substance abuse or mental health disorders. Do not include the co-occurring disorders employment hours verified in Part B.)

_____
NAME OF AGENCY WHERE SUPERVISION OCCURRED (PLEASE INCLUDE ADDRESS)

_____ _____
SUPERVISOR'S JOB TITLE AT TIME OF SUPERVISION APPLICANT'S JOB TITLE AT TIME OF SUPERVISION

APPLICANT'S DATES OF EMPLOYMENT IN COUNSELING:

From: _____/_____/_____ To: _____/_____/_____
Month Day Year *Month Day Year*

AVERAGE NUMBER OF HOURS APPLICANT WORKED PER WEEK: _____

TOTAL NUMBER OF HOURS PER WEEK SPENT IN DIRECT COUNSELING: _____

NUMBER OF HOURS OF COUNSELING PROVIDED IN THE FOLLOWING AREAS:

INDIVIDUAL COUNSELING _____ GROUP COUNSELING _____ FAMILY & SIGNIFICANT OTHER COUNSELING _____

CASELOAD AREAS:

PERCENTAGE OF CLIENTS WITH DIAGNOSIS OF ALCOHOL/DRUG ABUSE DISORDERS _____%

PERCENTAGE OF CLIENTS WITH DIAGNOSIS OF MENTAL ILLNESS _____%

PART C (Cont'd.)

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 AT THE TIME OF SUPERVISION.

_____

_____

_____

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_____

_____

_____

_____

ALL SUPERVISORS MUST COMPLETE PARTS D & E

PART D

DESCRIBE THE PROCEDURE USED IN SUPERVISION WITH THE APPLICANT. YOUR COMMENTS IN THIS PORTION ARE CONSIDERED *VERY* IMPORTANT. PLEASE COMPLETE IT CAREFULLY.

PART E

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE COUNSELOR –

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

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES (*please check only **one** statement)*:

- ❑ *I RECOMMEND THIS APPLICANT FOR CERTIFICATION*
- ❑ *I HAVE SOME RESERVATIONS IN RECOMMENDING THIS APPLICANT*

  Please specify _____
  _____
  _____

- ❑ *I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION*

  Please specify _____
  _____
  _____

THE SUPERVISOR COMPLETING THIS EVALUATION FORM MUST READ THE FOLLOWING STATEMENT AND SIGN WHERE DESIGNATED:

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

_____ _____

*SUPERVISOR'S NAME **(Please print here)*** *SUPERVISOR'S JOB TITLE*

_____ _____

SUPERVISOR'S SIGNATURE *DATE*