# 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, P.O. Box 1801 New Bedford, MA 02741-1801***

***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 INSTITUIONAL (DETENTION FAICLITIES)
     - ❑ 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:

- ❑ DYNAMICS OF ADDICTIONS AND CRIMINAL BEHAVIOR
- ❑ LEGAL, ETHICAL, AND PROFESSIONAL RESPONSIBILITY
- ❑ CRIMINAL JUSTICE SYSTEM AND PROCESSES
- ❑ SCREENING, INTAKE, AND ASSESSMENT
- ❑ CASE MANAGEMENT, MONITORING, AND CLIENT SUPERVISION
- ❑ COUNSELING

***WORK EXPERIENCE VERIFICATION (Cont'd.)***

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE APPLICANT:

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

I CERTIFY 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)*

I ATTEST 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*

*THIS CLINICAL SUPERVISOR VERIFICATION FORM IS* ***CONFIDENTIAL****.*

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

***PLEASE MAIL THIS COMPLETED FORM DIRECTLY BACK TO MBSACC AT:***

*MBSACC*
*560 LINCOLN STREET*
*P.O. BOS 7070*
*WORCESTER, MA 01605*

***MBSACC APPRECIATES AND THANKS YOU FOR YOUR COOPERATION***