MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

MBSACC

CLINICAL SUPERVISOR EVALUATION FORM

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 evaluator listed below.

______________________________ ______________________________
PRINT NAME OF CLINICAL SUPERVISOR APPLICANT'S SIGNATURE

I hereby waive my right to inspect this evaluation form and any subsequent information provided by the evaluator in connection with my application for Certification.

____
APPLICANT'S SIGNATURE

To the Clinical Supervisor:

The individual named above is applying to the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) for certification as a substance abuse counselor (CAC, CADC, or CADC-II). The information requested from you is an essential part of the Board's evaluation of the competence of this applicant, and this completed form must be on file before the application can be reviewed and processed.

The Board believes that your evaluation from direct observation and supervision of the applicant's work will contribute to a more complete and accurate impression of the knowledge and skill of the applicant. The Board appreciates your accurate and truthful reporting. This form is considered by the Board to be ***confidential****. As Supervisor, you may keep a photocopy of this evaluation for your files, but you must* ***not*** *provide a copy of this form, nor disclose its contents, to the applicant. You must mail it directly back to MBSACC. Failure to comply with this directive could void the entire application. MBSACC thanks you for your cooperation.*

PLEASE MAIL THIS EVALUATION DIRECTLY TO MBSACC AT:

MBSACC, P.O. Box 1801, New Bedford, MA 02741-1801

CLINICAL SUPERVISOR EVALUATION FORM **PART – A –**

_______________________________ _______________________________
SUPERVISOR'S NAME *SUPERVISOR'S JOB TITLE*

____
CURRENT AGENCY NAME & ADDRESS

(   )_____________________________ _______________________________
AGENCY PHONE # (PLEASE INCLUDE AREA CODE) *HIGHEST DEGREE HELD*

____
STATE LINCENSE(S)/CERTIFICATIONS HELD

RELATIONSHIP TO APPLICANT (PLEASE CHECK AS MANY AS APPLY):

- ❑ *CONSULTANT* ❑ *PAST SUPERVISOR*
- ❑ *PRESENT SUPERVISOR* ❑ *OTHER (PLEASE SPECIFY)*____________________________

____
AGENCY WHERE SUPERVISION OCCURRED (PLEASE INCLUDE ADDRESS)

WAS THIS AGENCY LICENSED? ❑ *Y* ❑ *N* *AS A SUBSTANCE ABUSE TREATMENT AGENCY?:* ❑ *Y* ❑ *N*

IF NOT SUBSTANCE ABUSE TREATMENT, PLEASE SPECIFY (BELOW) TYPE OF LICENSED AGENCY:

____

_______________________________ _______________________________
YOUR POSITION AT TIME OF SUPERVISION *APPLICANT'S POSITION AT TIME OF SUPERVISION*

SUPERVISION OF THE APPLICANT'S WORK OCCURRED:

FROM: ____________ TO: ____________
MONTH/YEAR *MONTH/YEAR*

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

AVERAGE NUMBER OF HOURS APPLICANT WORKED PER WEEK: ____________

TOTAL NUMBER OF HOURS PER WEEK IN DIRECT CLIENT SUBSTANCE ABUSE COUNSELING: ______________
DO *NOT* INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENT IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.)

WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASE LOAD? ______________

AVERAGE NUMBER OF HOURS PER WEEK OF SUBSTANCE ABUSE COUNSELING PROVIDED IN THE FOLLOWING AREAS:

INDIVIDUAL COUNSELING _________ *GROUP COUNSELING* ________ *FAMILY/SIGNIFICANT OTHER COUNSELING* _________

PERCENTAGE OF TIME SPENT IN THE FOLLOWING CASELOAD AREAS:

PRIMARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE __________%

PRIMARY DIAGNOSIS OF OTHER __________% *(PLEASE SPECIFY)* ______________________________

SECONDARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE __________%

CLINICAL SUPERVISOR EVALUATION FORM ***PART – B –***

IN THE LINES BELOW, PLEASE PROVIDE A BRIEF DESCRIPTION OF THE APPLICANT'S PRIMARY JOB RESPONSIBLITIES AS AN ALCOHOL/DRUG ABUSE COUNSELOR AT THE TIME OF SUPERVISION:

____

____

____

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

CLINICAL SUPERVISOR EVALUATION FORM ***PART – C –***

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE COUNSELOR –

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

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

APPLICANT'S NAME (PLEASE PRINT)

AGENCY NAME (PLEASE PRINT)

SUPERVISOR'S NAME (PLEASE PRINT)

SUPERVISOR'S SIGNATURE

DATE

*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.*

___ *I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION.*

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

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 SIGNATURE

____

SUPERVISOR'S JOB TITLE *DATE*

THIS CLINICAL SUPERVISOR EVALUATION FORM IS CONFIDENTIAL.

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

THE SUPERVISOR MAY MAKE A PHOTOCOPY OF THIS FORM FOR HIS/HER RECORDS, BUT NO COPY MAY BE PROVIDED TO THE APPLICANT, NOR SHOULD THE APPLICANT BE ALLOWED TO VIEW ITS CONTENTS.

PLEASE COMPLETE AND SIGN THIS FORM, AND MAIL IT DIRECTLY BACK TO:

MBSACC, P.O. Box 1801, New Bedford, MA 02741-1801

AN APPLICATION IS CONSIDERED INCOMPLETE WITHOUT THIS FORM, AND, IN MOST INSTANCES, MUST BE POSTMARKED BY A CERTAIN DEADLINE DATE. PLEASE CONFIRM WITH THE APPLICANT THE DEADLINE DATE BY WHICH THIS *EVALUATION FORM MUST BE POSTMARKED, AND POSTMARK THIS FORM ON OR BEFORE THAT DATE. THANK YOU FOR YOUR COOPERATION.*