CHEMICAL DEPENDENCY PROFESSIONALS BOARD
CLINICAL SUPERVISION
SUPERVISOR REFERENCE FORM

_____ _____
APPLICANT'S NAME APPLICANT'S FILE #

PART A: TO BE COMPLETED BY THE APPLICANT

1. Name: _____
   First Middle Last

2. Social Security #: _____

3. Address: _____
   Number Street City State Zip

4. Name of Supervisor: _____ Title: _____

5. Name and address of facility where supervision took place:

_____
_____
_____

6. Dates of clinical supervisory experience: From _____ To _____
   mo/yr mo/yr

   Number of hours worked per week at this setting: _____

   Total number of contact hours of face-to-face clinical supervision: _____
   (Must at a minimum document 200 hours)

WAIVER OF LIABILITY

I, _____, hereby authorize _____
(applicant) (supervisor)
to provide the Board all information which the Board may deem relevant to my qualifications as an applicant for licensure. I hereby release and discharge the supervisor from all claims arising out of the provision of such information.

_____ _____
Signature of Applicant Date

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PART B: TO BE COMPLETED BY SUPERVISOR

1. Professional credentials and/or licenses you hold: _____

2. I have reviewed the applicant's statements regarding his/her clinical supervision work experience. These statements: _____ ARE substantially correct.
   _____ ARE NOT substantially correct.

3. Are you aware of any unethical professional behavior by this applicant?
   _____ Yes, please explain _____
   _____
   _____
   _____ No

CLINICAL SUPERVISOR STATEMENT

I verify that I have acted as _____'s
(applicant)
clinical supervisor during his/her clinical supervision work experience. In my opinion, the applicant has demonstrated the necessary skills to become certified as a LICDC.

_____ _____
Supervisor's Signature Date