

# NOTIFICATION OF SUPERVISORY RELATIONSHIP FOR A CHEMICAL DEPENDENCY COUNSELOR ASSISTANT

Individuals who hold the Chemical Dependency Counselor Assistant (CDCA) credential must complete this form with their Clinical Supervisor within sixty (60) days of beginning each new supervisory relationship. **Intentionally false and/or misleading statements may result revocation of licensure/certification.**

**Please type or print legibly.**

Supervisee (CDCA) Name: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

Original Date of Certification: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Supervisor License (mark all that apply):

- LICDC-CS
- LPCC/LPCC-S
- LISW/LISW-S
- IMFT/IMFT, Supervision Designation
- MD/DO
- RN
- Licensed Psychologist

Type of Supervision to Occur:

- Clinical
- Administrative
- Both

Supervision Site:

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

We verify that we will maintain a supervisory relationship complying with ethical codes and standard of practice for the profession of Chemical Dependency counseling.

\_\_\_\_\_  
Supervisee Signature, Credentials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature, Credentials

\_\_\_\_\_  
Date