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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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COUNSELING EXPERIENCE VERIFICATION FORM

CHEMICAL DEPENDENCY PROFESSIONALS

INSTRUCTIONS – Upload this document when you submit your application

The purpose of this form is to verify the ***hours of substance abuse counseling*** that an applicant has provided while ***not*** under the ***supervision*** of an ***approved clinical supervisor***. Hours of counseling provided while under the supervision of an approved clinical supervisor are verified on the *Supervision Reference* form. Do not enter such supervised counseling hours on *this form.* This form is not required for applicants applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application*.** If the applicant was an employee, the applicant's clinical or administrative supervisor must complete the entire form and sign it. If the applicant was self-employed, the person whom the applicant designated as an objective agent must complete the entire form and sign it.

The applicant is not to complete any portion of this form!

The following definitions apply to the experience requirement:

- Professional counseling experience means hours spent providing chemical dependency counseling services in a substance abuse counseling setting, including face-to-face interaction with clients and other services directly related to treatment of clients.
- Counseling experience means a formal, systematic process that focuses on skill development and integration of knowledge related to addiction counseling and reflects the accumulation of hours spent providing substance abuse counseling services while under the supervision of an approved clinical supervisor.
- Supervised counseling experience means an approved clinical supervisor's oversight of a supervisee's application of chemical dependency counseling principles, methods or procedures to assist clients in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed chemical dependency professional, licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health or licensed physician specializing in chemical dependency treatment.

Applicants are required to have at least 3200 hours of post-Masters substance abuse counseling experience. Of the 3200 hours, at least 1600 hours must be ***counseling experience*** under the supervision of one or more ***approved clinical supervisors***. In addition, at least 100 of the 1600 hours of supervised counseling experience must be face-to-face consultation between the applicant and his/her approved clinical supervisors. These hours may take place in individual and/or in group settings, as follows:

- The entire 100-hour requirement may be met by individual supervision, which means one-to-one, face-to-face meetings between the applicant and supervisor.
- No more than 40 hours of the 100-hour requirement may be met by group supervision, which means face-to-face meetings between the applicant, the supervisor and up to five other supervisees.

The experience requirements are in 24 *Del. C*. §3044 of the license law and in the Board's Rules and Regulations. Both are available at www.dpr.delaware.gov.

INFORMATION ABOUT APPLICANT

1. Applicant Name: _____ _____ _____
   Last First Middle

INFORMATION ABOUT SUPERVISOR OR AGENT

2. Supervisor/Agent Name: _____ _____ _____
   Last First Middle

3. Title: _____

4. Phone: _____ Email: _____

5. Check your association to the applicant:

   ☐ Clinical Supervisor – skip to the **VERIFICATION OF COUNSELING HOURS** section.

   ☐ Administrative Supervisor – skip to the **VERIFICATION OF COUNSELING HOURS** section.

   ☐ Objective Agent – continue with the next question.

6. Do you have personal knowledge of the extent of the applicant's professional practice while he or she was self-employed? Yes ☐ No ☐ If yes, explain your professional relationship to the applicant: _____

   _____

7. Are you related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law? Yes ☐ No ☐ If yes, specify relationship: _____

VERIFICATION OF COUNSELING HOURS

8. Enter the following information about the setting/location where the applicant provided substance abuse counseling:

   Name: _____

   Address: _____

   _____ _____ _____
   City State Zip

   Description: ☐ Alcohol and drug treatment center ☐ Outpatient or detox ☐ Residential ☐ Methadone clinic
   ☐ Partial hospital program ☐ Hospital setting ☐ School setting
   ☐ Other: _____

9. Enter the dates that the applicant provided substance abuse counseling at this setting/location:

   From _____ To _____
   Month/Year Month/Year

   Calculate and enter a total number of hours in the questions below. Answers such as "40 hours/week" will not be accepted.

10. During this period, how many ***TOTAL*** hours of ***unsupervised*** substance abuse counseling did the applicant provide in this setting/location? _____

SUPERVISOR OR AGENT CERTIFICATION

I certify that I personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties.

Supervisor/Agent Signature: _____ Date: _____

Upload this document when you submit your application