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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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SUPERVISION REFERENCE

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 under the ***supervision*** of an ***approved clinical supervisor***. 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*.** The clinical supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above.

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.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Direct Supervisor Name: _____ _____ _____
   Last First Middle

   Direct Supervisor Title: _____

3. Practice Address: _____

   _____ _____ _____
   City State Zip

4. Phone: _____ Email: _____

5. Provide the following information about the professional licenses you held at the time you supervised the applicant.

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
☐	Chemical Dependency Professional			
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Physician *(specializing in chemical dependency treatment)*			
☐	Clinical Psychologist			

VERIFICATION OF EXPERIENCE HOURS

6. Did you provide the applicant with ***supervised*** counseling experience, as defined in Instructions, to this applicant? Yes ☐ No ☐ If no, you may have received this form in error. If you can verify the applicant's *unsupervised* counseling experience, the correct form is the *Counseling Experience Verification Form.* If you know who provided the applicant with face-to-face supervision, enter the following information and then skip to the **Signature**:

   Name of Supervisor:_____

   Setting/Location Where Supervision Occurred: _____

7. Enter the following information about the setting/location where you supervised the applicant named above:

   Setting/Location Name: _____

   Address: _____

   Description (e.g., private practice, community mental health agency, etc.): _____

8. Enter the dates of that you supervised the applicant:

   From _____ To _____
   Month/Year Month/Year

9. During this period, how many total hours of substance abuse counseling did the applicant provide while under your supervision? _____

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

10. During this period, how many total hours of face-to-face, individual (one-on-one) supervision, as defined in Instructions, did you provide to the applicant? _____

11. During this period, how many total hours of face-to-face, group supervision, as defined in Instructions, did you provide to the applicant? _____

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.

Clinical Supervisor Signature: _____ Date: _____

Upload this document when you submit your application