

Clinical Supervision Verification

SUDA Applicant Information				
Name				
Address				
City				
State				
Contact Number				
Email				
Application Date				
CLINICAL SUPERVISION VERIFICATION				
Requirement Applicant must meet one of the criteria below and provide documentation Check ✓ the one that applies				
	I am a CADC wl supervision	no has been certified for 3 years and has completed 15 hours of training in		
	I am an ACADC			
	I am a CCS			
	I am a person with aMaster's degree and license in addictions counseling or Master's degree and certification in addictions counseling			
	l am an approve	ed Health & Welfare Clinical Supervisor (QP) under IDAPA 16.07.20.02		

Applicant Documentation

Requirement

A copy of supervisors' licensure and/or proof of supervisory training must be submitted with this form.

A minimum of one-third of the total number of hours shall be dedicated to individual time with the supervisor, and the remaining two-thirds of the total hours can be conducted in group setting and shall include discussion of problem cases.

Clinical Supervisor *Must be original	
Certification #	
Individual supervision hours	
Group supervision hours *cannot include education/classroom hours	
Total supervision hours *Individual and Group	

12 Core Functions

Reference

IBADCC > 12 Core Functions

The Substance Use Disorders Associate CANNOT perform any of the 12 Core Functions independently (unobserved) until the clinical supervisor ascertains the competency of the trainee. Documentation of this competency must be noted on this form and retained in the trainee's file.

Areas identified by clinical supervisor for professional development in 12 Core Functions

Identified plan for professional development



Idaho Board of Alcohol/Drug Counselor Certification, Inc.

	Signature
Requirement Must be original	
Applicant Signature	
Date	
Supervisor Signature	
Date	
Title & Agency	

Next Step				
Mail this form and all supporting documentation to:				
IBADCC 824 S. Diamond St. Nampa, ID 83686				