STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
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KATIE HOBBS
Governor

TOBI ZAVALA
Executive Director

ADDICTION COUNSELING
VERIFICATION OF SUPERVISED WORK EXPERIENCE FORM

HOW TO SUBMIT		
EMAIL applications@azbbhe.us Emailed forms must only come from the Direct Supervisor.	**OR**	**SEALED ENVELOPE** Direct Supervisor's signature MUST be on the seal.

- **Form must be completed by the Direct Supervisor.**
- Include a copy of the published job description for the position(s) supervisee held during the period of work experience reported.
- Do not complete this form if you are a supervisor hired outside of the agency (other than those hired/approved by the Board to do Supervised Private Practice).

SCOPE OF PRACTICE
R4-6-101 (A) (44)

"Practice of substance abuse counseling" means the professional application of general counseling theories, principles and techniques as specifically adapted, based on research and clinical experience, to the specialized needs and characteristics of persons who are experiencing substance abuse, chemical dependency and related problems and to the families of those persons. The practice of substance abuse counseling includes the following as they relate to substance abuse and chemical dependency issues:

a. Assessment, appraisal, and diagnosis.
b. The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups. A.R.S. § 32-3251.

A	SUPERVISEE INFORMATION		
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	Legal Name (First Name Last name)		
Current AZ Board License(s) #	Issue Date(s)	Expiration Date(s)	
Agency/Practice Name		Supervisee's Title or Position	
Address		Preferred Phone	
City	State / Zip Code	Supervisee Was An: ☐ Employee ☐ Independent Contractor	
Describe the supervisee's scope of practice and specific work activities during the period of supervised work experience being verified:			
Did supervisee have ownership in or manage the practice where supervision occurred? ☐ YES ☐ NO			

B EMPLOYER OR SUPERVISOR INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	Legal Name (First Name Last name)	
Current license(s) # (if applicable)	Title	Preferred phone
During supervision I was: ☐ Owner/Supervisor ☐ Hired for supervised private practice ☐ Other (explain below):		Email

C REPORT OF SUPERVISED WORK EXPERIENCE HOURS

REPORTING PERIOD: *(Do NOT use "current" or "present")*

_____ to _____

Start Date (month, day, & year) *End Date (month, day, & year)*

Was qualifying clinical supervision provided throughout the entire time period being verified above?

☐ YES ☐ NO

If NO, do not include work experience hours for the months that supervisee did not receive clinical supervision. Please list the months that clinical supervision was not provided and give an explanation below:

D SUPERVISED WORK EXPERIENCE HOURS

1. Total hours of client contact involving **psychotherapy**	
2. Total hours of client contact involving **psychoeducation**	
TOTAL HOURS OF SUPERVISED WORK EXPERIENCE **in the practice of substance abuse counseling** in reporting period (auto-calculated)	0

R4-6-101 (A) (23) "**Direct client contact"** means the performance of therapeutic or clinical functions related to the applicant's professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients.

R4-6-101 (A) (46) "**Psychoeducation**" means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health." A.R.S. § 32-3251.

E EMPLOYER/SUPERVISOR ATTESTATION

I, _____ (Employer/Supervisor), certify that:

- _____ (Supervisee):
  - Was engaged in the supervised practice of substance abuse counseling (including assessment, diagnosis and treatment) that met the Board's requirements as reported above.
  - Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care.
  - Has a rating of at least satisfactory in overall performance.
- I agree to provide documentation upon request to validate the supervised work experience hours reported above.
- All information contained in this verification, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board not accepting the applicant's supervised work experience hours and/or denying their licensure application.

_____ _____

Signature of Supervisor Date