



CSAC-A VERIFICATION OF EXPERIENCE WHILE UNDER SUPERVISION

GENERAL INFORMATION			PLEASE TYPE OR PRINT CLEARLY		
Name of Applicant (Last, First, Middle)			Applicants Email Address		
SUPERVISOR'S EVALUATION:					
Supervisor's Name (Last, First)		Supervisor's License or Certification Number		Supervisor's Telephone Number	
Worksite Name and Address where substance abuse tasks where performed:					
Dates of supervision: From: _____ to _____					
Did the applicant complete a minimum of 180 hours of experience performing the following tasks with substance abuse clients with <u>at least eight hours</u> for each task?					
a. Screening clients and gathering information used in making the determination for the need for additional professional assistance;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Intake of clients by performing the administrative tasks necessary for admission to a program;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Assisting the client in identifying and ranking problems to be addressed, establishing goals, and agreeing on treatment processes;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Implementation of a substance abuse treatment plan as directed by the supervisor;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Implementation of case management activities that bring services, agencies, people, and resources together in a planned framework of action to achieve established goals;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Assistance in identifying appropriate crisis intervention responses to a client's needs during acute mental, emotional or physical distress;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Education of clients by providing information about drug abuse and available services and resources;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;				<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Reporting and charting information about client's treatment, progress, and other client-related data; and				<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Consultation with other professionals to assure comprehensive quality care for the client				<input type="checkbox"/> Yes <input type="checkbox"/> No	
In your opinion has the applicant demonstrated competency sufficient for certification as a substance abuse counseling - assistant?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
I declare that, to the best of my knowledge, the foregoing is true and correct.					
_____ Supervisor's Signature				_____ Date	