STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF ALCOHOL AND DRUG COUNSELORS WORK EXPERIENCE OR INTERNSHIP

TO BE COMPLETED BY APPLICANT

APPLICANT: Complete this portion and forward a copy to the appropriate organization(s) where you completed paid work experience or an unpaid internship.

Applicant's Name: ____________________________________ Date of Birth: _____ / ____ / ______

Day Time Telephone: _________________________________

TO BE COMPLETED BY SUPERVISOR

SUPERVISOR'S CREDENTIALS

Note: In order to qualify as an acceptable supervisor, individuals other than A&DCs must have completed 50 hours of specialized alcohol and drug counseling education in the areas of pharmacology, assessment and treatment planning, and treatment techniques and have experience working directly with persons who have been assessed or diagnosed as having an alcohol or other drug abuse dependency.

____ ____

Name & Title *Telephone Number*

Address: ____

If work experience/internship was completed in Connecticut, please check one of the following as appropriate:

☐ I am a Connecticut licensed alcohol and drug counselor, license # ________________________________

☐ I am certified as a Clinical Supervisor by the Connecticut Certification Board. Certification # __________

☐ I am licensed in Connecticut as a ______________________________, license #___________________ and am qualified as an acceptable supervisor as stated above.

If work experience/internship was completed outside of Connecticut, please check one of the following as appropriate:

☐ I am licensed in the state in which the work experience/internship was completed to practice:

☐ alcohol & drug counseling	☐ registered nursing
☐ medicine and surgery	☐ psychology
☐ clinical social work	☐ professional counseling
☐ marital and family therapy	☐ advanced practice registered nursing

State ____________________________ License # _______________________

DETAILS OF WORK EXPERIENCE/INTERNSHIP

This is to verify that the applicant identified above completed work experience/internship under my supervision from _______/_______/_______ to _______/_______/_______.

Name and address of organization where work experience/internship was completed:

____

____

Type of experience being verified? (Check one) ☐ Paid Work Experience ☐ Unpaid Internship

Did the experience include working directly with persons who have been assessed or diagnosed as having an alcohol or other drug abuse dependency and providing specific counseling interventions that are directed toward the amelioration of a substance use disorder and that are identified in a treatment plan and encompass all of the core counseling functions? YES ☐ NO ☐.

Hours worked per week ________________ weeks per year ________________

Number of hours considered to be full-time at employment site _______________

Total number of hours completed as a part of work experience/internship __________________

Of the total hours completed, how many hours were in the counseling core function? _______

I certify that I qualify as an acceptable supervisor in accordance with the requirements identified above and that all of the statements contained herein are true and correct to the best of my knowledge and belief.

_______________________________________ _______________________________________

Name of Person Completing Form *Telephone Number*

_______________________________________ _______________________________________

Signature *Date*

Thank you for your assistance. This form must be returned directly by the verifying authority to:

Department of Public Health
ADC Licensure/Certification
410 Capitol Ave., MS #12APP
P.O. Box 340308
Hartford, CT 06134-0308