Supervisee's Name: _____

KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero St, 2 SC 32, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ http://adc.ky.gov

VERIFICATION OF CLINICAL SUPERVISION

Highest Educational Level Achieved: _____

Documentation of direct supervision by a Board-Approved Certified Alcohol and Drug Counselor or a Licensed Clinical Alcohol and Drug Counselor must be provided. This form must becompleted by the applicant and signed by the clinical supervisor.

Clinical supervision shall meet the following minimum requirements:
(a) Applicants with a high school diploma or high school equivalency diploma require 300 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains;
(b) Applicants with an associate's degree in a relevant field require 250 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains;
(c) Applicants with an bachelor's degree in a relevant field require 200 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains; and
(d) Applicants with an master's degree or higher in a relevant field require 100 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains.

In accordance with 201 KAR 35:010, Section 1 (12), "clinical supervision" means a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive. These activities are observed/reviewed by the clinical supervisor who provides timely positive and constructive feedback to assist the counselor in the learning process. Methods of supervision include: face-to-face, video, observation, or telephone/conference. **A minimum of 10 hours of face-to-face clinical supervision must be documented in each of the four (4) domains**.

APPLICANT/SUPERVISEE'S NAME: _____

APPLICANT/SUPERVISEE'S STRENGTHS: _____

_____

_____

_____

APPLICANT/SUPERVISEE'S WEAKNESSES:_____

_____

_____

_____

Supervisee's Name: _____

COMPLETE THE FOLLOWING **SUMMARY** OF CLINICAL SUPERVISION HOURS - SPECIFIC DETAILS MUST ACCOMPANY THIS PAGE. USE AS MANY PAGES AS NECESSARY TO PROVIDE DETAILS OF CLINICAL SUPERVISION. NUMBER EACH PAGE.

DOMAIN	**Number of Face-to-Face Hours**	**TOTAL NUMBER OF HOURS**
Screening assessment and engagement		
Treatment planning, collaboration, and referral		
Counseling		
Professional and ethical responsibilities		
TOTAL		

Affidavit: I verify, under the penalty of perjury, that the information documented above is true and accurate to the best of myknowledge and belief.

Applicant Signature:_____Date: _____

Supervisee's Name: _____

DOMAIN 1: SCREENING ASSESSEMENT AND ENGAGEMENT

(Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Screening Assessment and Engagement _____

Supervisee's Name: _____

DOMAIN 2: TREATMENT PLANNING, COLLABORATION, AND REFERRAL

(Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Treatment Planning, Collaboration, and Referral _____

Supervisor's Name _____

DOMAIN 3: COUNSELING

(Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Counseling _____

<u>DOMAIN 4</u>: PROFESSIONAL AND ETHICAL RESPONSIBILITIES

(Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Professional and Ethical Responsibilities _____