



KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero Street, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ <http://adc.ky.gov>

SUPERVISION ANNUAL REPORT

SUPERVISEE INFORMATION

First Name _____ Middle Name _____ Last Name _____

/ / () - () -
Social Security Number Home Telephone Work Telephone

Street Address _____

Email Address _____ Peer Support/Certification/License Number _____

City _____ State _____ Zip Code _____

In the past year, I have completed _____ hours of supervision during the designated reporting time period.

SUPERVISOR INFORMATION

First Name _____ Middle Name _____ Last Name _____

Street Address _____

Email Address _____

City _____ State _____ Zip Code _____

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Telephone Number Type of Cert./ License Held Cert./Lic.Number

/ / / /
Date of issue (attach a copy) Expiration Date (Attach a copy)

INFORMATION RELATED TO SUPERVISED EXPERIENCE

Please complete a separate form for each setting

Applicant Name

Organization or Agency

Street Address of Organization or Agency

City

State

Zip Code

I am seeing my supervisor at least 2 hours 2 times a month Yes No

I, as the supervisee, affirm that all information provided by me on this form is true and accurate and I affirm the following:

That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;

That I will meet with my supervisor two hours two times a month of documented supervised experience;

That I will abide by all rules of the board, including ethics requirements;

That I notify the board if this supervisory arrangement is terminated; and

That I understand any additional supervisors and settings shall be approved by the board in advance.

Signature of Applicant

Date

Signature of Supervisor

Date

THE SUPERVISOR AND SUPERVISEE SHOULD KEEP A COPY OF THIS FORM FOR RECORDS