Printed/typed name of Applicant: _____

Minnesota Board of Behavioral Health and Therapy
ADC Verification of Past Supervised Professional Practice

1. Please use this form if any or all of your supervised professional practice took place before July 1, 2005.

2. If, upon completion of your education requirements, you worked as an alcohol and drug counselor, either unlicensed; with a temporary permit; licensed, certified or credentialed in another jurisdiction; or pursuant to the authority of another professional license, **and** you received professional supervision while performing this work, you may seek to have these hours applied to the 2000 hours of supervised professional practice described in Minnesota Statutes sections 148C.04, subd. 3(2)(ii), 148C.04, subd. 4(1)(ii), 148C.044, or 148C.11, subd. 1(c). For purposes of this requirement, the supervision must have been clinical in nature and not employment related supervision.

3. If you received supervised experience at more than one setting or with more than one supervisor, you must provide the information below on a separate form for each supervisor and/or setting.

4. Upon review of the information, the Board will notify you in writing whether you have completed the requirement, in whole or in part. You may not practice independently until the Board has notified you in writing that you may do so.

5. In addition to providing the information below, your supervisor must complete and submit either (1) a Supervisor Credential Verification form if all of the supervision occurred on or *before* June 30, 2005 or (2) a Supervisor Application form if any part of the supervision occurred on or *after* July 1, 2005.

Date supervision began: _____ Date supervision ended: _____

Name of Supervisee: _____

Name of Supervisor: _____

Supervisor's Licensure/Credentials: _____

Name of supervision location (Business): _____

Address of supervision location: _____

Number of on-the-job hours scheduled to work: □ per week □ per month _____

Number of hours of in-person supervision completed: □ per week □ per month _____

Total number of supervised professional practice hours (Example: 1 year of full time employment, 40 hours/wk is 2,080 hours): _____

Describe the types of clients seen at this setting: _____
_____
_____
_____

Describe how the supervision was conducted, including scheduling of supervision and documentation of supervision sessions:
_____
_____
_____

Printed/typed name of Applicant: _____

Record the approximate percentage of time supervisee spent in the professional activities listed below.

Screening:	%	Case Management:	%
Intake:	%	Crisis Intervention:	%
Orientation:	%	Client Education:	%
Assessment:	%	Referral:	%
Treatment Planning:	%	Reports & Recordkeeping:	%
Counseling:	%	Consultation with Other Professionals	%

*For the **supervisee** to complete*:

I, the undersigned, have read and agree that the supervision was conducted as described above, and that the information contained therein is true and correct to the best of my knowledge.

Supervisee signature: _____ Date: _____

*For the **supervisor** to complete*:

I, the undersigned, have read and agree that the supervision was conducted as described above, and that the information contained therein is true and correct to the best of my knowledge.

Supervisor signature: _____ Date: _____

Supervisor: Please **initial** the following certifying statements (if you do not agree to initial these statements, please explain in a separate written statement the reasons you are in disagreement with them):

_____ I certify that the 2,000 hours of supervised professional practice of the above listed supervisee that I supervised was within the scope of practice of alcohol and drug counseling as defined by Minnesota Statutes section 148C.01, subdivision 10.

_____ I certify that the supervision was completed satisfactorily.