CREDIT FOR WORK EXPERIENCE FORM

CASE MANAGEMENT

Name of Applicant: _____

Name of Clinical Supervisor: _____

The Clinical Supervisor must have provided direct clinical supervision to the applicant during the time frame referenced in this request and must be a Master's level clinician. Acceptable credentials include LCPC, LCSW, APRN, Psychologist, MD/DO, and Psychiatrist. For a complete listing of acceptable credentials, please refer to the MHRT/C Procedural Guidelines.

Dates of Supervision (start & end): _____

Please note that each request for work credit must have its own specified and distinct time frame. No overlapping of dates and courses is permitted.

By initialing **each** knowledge competency for this MHRT/C requirement below the Clinical Supervisor attests that the applicant has a high level of competence in them. **Please attach one or more sheets summarizing the work the applicant has performed under supervision that relates directly to these competencies for this course. Please give specific examples of how the applicant has demonstrated these competencies in their work. Clinical supervisor must sign each additional page.**

____ Understands importance of community inclusion and use of natural supports

____ Understands Maine's laws regarding mental health recipients' rights

____ Understands benefit and entitlement programs

____ Understands interaction of co-occurring medical issues

____ Knowledgeable about changing treatment needs for adult stages of transition

____ Understands basic social services and entitlements

____ Knowledge of community provider system

____ Knowledge of generic community resources including available natural supports

____ Understands ethics and conducts practice in a professional manner

____ Aware of the need to act as a contributing member of an interdisciplinary team

____ Knowledge of confidentiality

____ Aware of the need to evaluate effectiveness of personal practice

____ Understands effective use of supervision

____ Interacts effectively with community members and other professionals

____ Understands strategies that empower consumers

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By signing below, I confirm that I provided direct clinical supervision to the applicant during the time referenced in this request. I have discussed the knowledge competencies for this course with this individual and attest that this individual has acquired the competencies for the course to be credited as listed in the Procedural Guidelines for MHRT/C.

Signature of Clinical Supervisor	License Type & Number	Date

Please sign, date, and return to applicant. Applicant must submit this form as part of their application. For complete requirements regarding credit for work requests, please refer to the *Guidelines for MHRT/C Certification.*