CREDIT FOR WORK EXPERIENCE FORM

PSYCHOSOCIAL REHABILITATION

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 a document 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.**

____ Aware of outcomes-based research regarding people with psychiatric disabilities

____ Understands effective psychosocial rehabilitation interventions to help individuals with psychiatric disabilities function successfully in the community

____ Knowledgeable about collaborative planning with people with psychiatric disabilities including the following: goal setting, skill assessment and training, and linking with supports in the community

____ Identifies and respects consumer choice

____ Knowledge of generic community resources including available natural supports

____ Understands strategies that empower consumers

☐ I have enclosed a document summarizing how the applicant has met these knowledge competencies in their work. (Please check when completed.)

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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.*