

**CREDIT FOR WORK EXPERIENCE FORM**  
**SUBSTANCE ABUSE WITH A DUAL DIAGNOSIS COMPONENT**

**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.**

\_\_\_\_ Aware of prevalence and common effects of co-occurring disorders (substance abuse and mental health)

\_\_\_\_ Aware of screening and assessment strategies for co-occurring disorders (substance abuse and mental health)

\_\_\_\_ Aware of stages of recovery of persons who have co-occurring disorders

\_\_\_\_ Knowledgeable about resources to assist in recovery process for persons who experience co-occurring disorders

\_\_\_\_ Aware of the need to evaluate effectiveness of personal practice

\_\_\_\_ Understands effective use of supervision

***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*.