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 domains is permitted.

By initialing below the Clinical Supervisor attests that the applicant has a high level of competence in **each** knowledge competency for this MHRT/C requirement as follows:

____ 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

Please attach one or more sheets summarizing the work the applicant has performed under supervision that relates directly to the competencies above for this domain. Please give specific examples of how the applicant has demonstrated these competencies in their work. Clinical supervisor must sign each additional page.

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 domain with this individual and attest that this individual has acquired the competencies for the domain 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.*