CERTIFIED CLINICAL SUPERVISOR RELEASE FORM

I, ___________________________, grant Indiana Association of Addiction Professionals (IAAP) permission to post the following information about myself on their organization website for the purpose of supervisory locator.

NAME: ____

CREDENTIALS:____

BUSINESS NAME:____

BUSINESS ADDRESS:____

____

CITY:____

STATE/ZIP CODE:___________________________

EMAIL:____

OFFICE PHONE:_____________________________

CELL PHONE:________________________________

FAX:_______________________________________

SIGNATURE:___________________________________DATE:____________________