



2346 S. Lynhurst Drive, Suite D101  
Indianapolis, IN 46241  
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## Certified Clinical Supervisor Application 2018-2020

### I. Personal Data

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: (w) \_\_\_\_/\_\_\_\_/\_\_\_\_ (h) \_\_\_\_/\_\_\_\_/\_\_\_\_ (c) \_\_\_\_/\_\_\_\_/\_\_\_\_

FAX: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Are you an IAAP member: \_\_\_No \_\_\_Yes ID # \_\_\_\_\_ Expiration Date \_\_\_\_\_

### II. Education Record/Licensure/Certification

*Education:* Please list your educational achievement

Degree	University	Year Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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*Current License/Certification:* Please list each License/Certification/Degree you currently hold:

Credential #	Issuing Authority	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Note:** Copies of current Licenses/Certifications/Degrees *must* be attached.

**Important:** You *MUST* attach a copy of your IAAP Certificate(s) of Attendance for the minimum of 12 required clock hours of Clinical Supervision training, *or your application can not be processed.*

### III. Career History

In providing your addiction counseling career history, please list your current position first and work backwards until you document a minimum of three (3) years experience (6,000 hours) as an Addiction Counselor with a minimum of two (2) years post graduate experience. Attach additional pages as needed.

**Employer:** \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_

**Employer:** \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_

**Employer:** \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_

### IV. Verification of Work Experience

In the box provided below, have your supervisor (or other knowledgeable individual) verify your work experience, counseling skills and the contents of this application.

By affixing my signature hereto, I verify that I have supervised the person named in this application for \_\_\_\_ years, and that, to the best of my knowledge, the career history listed above is accurate and true. I further verify that the applicant is able to competently perform all required counseling skills and functions, and performs them within accepted ethical guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone: \_\_\_\_/\_\_\_\_

## Agency Verification

If the supervisor is no longer with the agency; the candidate can obtain employment verification from the Personnel/Human Resources Manager to verify Full-Time/Part-Time employment, years employed and in what capacity.

By affixing my signature hereto, I verify that the supervisor named in this application worked for our agency during the years listed in this application, and that, to the best of my knowledge, the career history listed above is accurate and true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone: \_\_\_\_/\_\_\_\_\_

## V. Candidate Affirmation

By affixing my signature hereto, I affirm that: the information on this application is true, accurate, correct, and complete: that I agree to abide by the principles within the IAAP Code of Ethics; and that my current license and/or certificate is not encumbered in any manner, nor has been subject to any criminal or ethical complaints.

I hereby authorize the IAAP Certification Committee to contact any institution, organization or individual listed on or included within this Application for verification on my addiction counseling history. I understand that IAAP Certification Committee retains physical ownership of all certificates, and my make available certificate holder names and other information to potential service users.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## VI. Application Checklist

- \_\_\_ Application Form
- \_\_\_ License/Certification Copies
- \_\_\_ Education/Training Certificate Copies
- \_\_\_ Supervisor's Signature (Section IV)
- \_\_\_ Your Signature (Section V)
- \_\_\_ Payment (Section VII)

## VII. Payment

**Members \$80.00 for 2 Year Certification**

**Non-Members \$215.00 for 2 Year Certification**

Amount Enclosed: \_\_\_\_\_ Check (payable to IAAP) \_\_\_\_\_ Money Order \_\_\_\_\_

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**FOR OFFICE USE ONLY**

\_\_\_ Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it complete and correct. Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ NOT Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it incomplete or incorrect, and needing the following information/correction(s) for approval:

\_\_\_\_\_  
\_\_\_\_\_

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Decision Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

IAAP Licensure Committee Chair