IAAP
The Indiana Association for Addiction Professionals
A NAADAC Affiliate

2346 S. Lynhurst Drive, Suite D101
Indianapolis, IN 46241
PH: (317) 481-9255
FAX: (317)481-1825

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

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 ____

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