Clinical Supervisor Confirmation Form

Thank you for your interest in the Addiction Training and Workforce Development Program.

Note: If you are currently working at a substance abuse treatment agency or mental health agency licensed by the Division of Mental Health and Addiction Services or a state psychiatric hospital, your application cannot be reviewed if the following supervisor information is incomplete.

If you are **not** currently working in the field, you may disregard this form. You will be notified after your application is reviewed to let you know whether or not you have been accepted into our program as a Provisional Student.

Before we can process your application, please have your **Clinical Supervisor** complete this information and fax it to NJPN at 732-367-9985.

Applicant's Name: ____

Employer: ____

Clinical Supervisor's Name	
Clinical Supervisor's Title	
Clinical Supervisor's Credentials	
E-mail Address (Required)	
Phone number	
Are you eligible to supervise CADC interns under New Jersey law (13:34C-6.2)?	**Yes** **No**
Will you be/are you the applicant's internship supervisor?	**Yes** **No**
Have you submitted a Proposed Plan of Supervision for this individual to the Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners', Alcohol and Drug Counselor Committee?	**Yes** **No**

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Clinical Supervisor's Signature *Date*

Please return this information to NJPN via fax at 732-367-9985.