Clinical Supervisor Confirmation Form

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

Your application review cannot occur until your **Clinical Supervisor** completes and signs this form. Once completed, please email or fax the form to Marisa Lierni: EMAIL: Marisa@njpn.org | FAX: 732.367.9985

To be completed by Clinical Supervisor

AGENCY INFORMATION

DMHAS-LICENSED AGENCY: _____

APPLICANT'S FULL NAME: _____

APPLICANT'S POSITION/TITLE: _____

APPLICANT'S JOB DESCRIPTION AS IT RELATES TO THE 12-CORE COMPETENCIES: _____

_____

CLINICAL SUPERVISOR INFORMATION

NAME: _____

TITLE: _____

CREDENTIAL(S): _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

	Circle One	
Are you eligible to supervise CADC interns under New Jersey law (13:34C-6.2)?	YES	NO
Are you supervising the above applicant's hours as a Counselor Intern in the 12 core functions?	YES	NO
Have you submitted a Proposed Plan of Supervision for the above applicant to the Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee? *A copy of the PPS is required before scholarship can be issued.*	YES	NO

My signature below confirms the information on this form is valid and the applicant has begun work towards the required 3,000 supervised hours in the 12 core functions under my supervision.

I understand that it is my responsibility to notify NJPN if the applicant is no longer under my supervision.

_____ _____

Clinical Supervisor Signature *Date*