NORTH DAKOTA BOARD OF ADDICTION COUNSELING EXAMINERS

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RETURN FORM TO:
North Dakota Board of Addiction Counseling Examiners
505 Kansas City St., Rapid City, SD 57701
Or email an electronic copy to board@ndbace.org

Clinical Supervisor Requirements and Application

The following qualifications and conditions must be met to receive approval as a clinical supervisor.

1. The applicant must have three years (6,000 hours) of supervised experience as a licensed addiction counselor.
2. The applicant must have completed a minimum of twenty contact hours of continuing education in clinical supervision.
3. The applicant must submit two letters of reference and recommendation from board-registered clinical supervisors.

Individuals choosing to continue their clinical supervisor registration must submit verification of completion of 8 hours of clinical supervision-related coursework within the two-year continuing education cycle in order to maintain clinical supervisor status.

Clinical Supervisor Application

I. IDENTIFYING INFORMATION (type or print)

a. Last Name: _____ First Name:_____

Middle Name: _____ Maiden Name: _____

b. Present Home Address: _____

c. Home Phone: _____ Work Phone: _____

d. Email Address: _____

II. CURRENT EMPLOYMENT

a. Agency: _____

b. Address: _____

c. Clinical Supervisor's Name:_____

d. Dates of Employment: _____

III. EMPLOYMENT HISTORY
(Last three years of employment)

a. Agency: _____

b. Address\Phone: _____

c. Clinical Supervisor's Name:_____

d. Dates of Employment: _____

e. Agency: _____

f. Address\Phone: _____

g. Clinical Supervisor's Name:_____

h. Dates of Employment: _____

IV. NORTH DAKOTA LICENSE INFORMATION

a. ND License Number:_____

b. Dates of original certification/licensure: _____

c. Years of licensed/certified addiction counseling experience: _____

V. CONTINUING EDUCATION VERIFICATION

a. Attach verification of 20 hours of clinical supervision continuing education contact hours.

VI. SIGNATURE

I verify that this information is true in every respect.

_____ _____

Date Signature of Applicant

_____ _____

Date Signature of Clinical Supervisor