Reset Form

FORM S2 – VERIFICATION OF SUPERVISION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 52957 (R1 / 8-24)

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
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GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right-corner above.*

SECTION A – APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B.*** *You must submit proof that you have acquired at least two hundred (200) hours of post-graduate face-to-face supervision, which must be comprised of one hundred (100) hours of individual supervision and one hundred (100) hours of group supervision as described in IC 25-23.6-10.5-8. This supervision must be completed while employed for no less than twenty-one (21) months and no more than forty-eight (48) months. The supervision must have been provided by a "qualified supervisor" as defined in 839 IAC 1-5.5-4. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name of Applicant (*last, first, middle, maiden or previous)*	Date of Birth *(month, day year)*

Name of Supervisor (please also provide supervisors	Employment of Supervisor

Applicant's employer during the time of supervision

Dates of supervision began *(month, day, year)*	Dates of supervision ends *(month, day, year)*

SECTION B - SUPERVISOR INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision documented in this form is to be specific to clinical addiction counseling. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" provided under IC 25-23.6-10.5-8.*

Total number of months of face-to-face supervision you provided to the above-named applicant: _____

Total number of supervision hours you provided to the above-named applicant: _____

Total number of individual supervision hours you provided to the above-named applicant: _____

Total number of group supervision hours you provided to the above-named applicant: _____

The above-named applicant was providing clinical addiction counseling services directly to clients at the time of my supervision?

☐ Yes ☐ No If No, please explain: _____.

I hold the following graduate degree(s), credential(s), and / or state board issued license(s) / certification(s) that qualify me to serve as a clinical addiction counselor supervisor:

_____

_____

I affirm that the above information is true and correct to the best of my knowledge and belief. I affirm that any virtual supervision completed met the definition of "virtual supervision" under IC 25-23.6-10.5-8.

Signature of supervisor, [please provide your professional credential (i.e., LCAC)]: _____

Printed name of supervisor, [please provide your professional credential (i.e., LCAC)]: _____

Cellular telephone number: _____

Work Telephone number: _____

E-mail address: _____

Date *(month, day, year):* _____

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SECTION C - AFFIRMATION OF SUPERVISION [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate the reason why the applicant's direct supervisor is no longer able to complete SECTION B:

The applicant's supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

_____

Supervision was provided by: _____.
(Name of supervisor / last, first, middle, maiden)

Total number of hours of face-to-face supervision the applicant received from this supervisor while providing clinical addiction counseling services directly to clients: _____.

Total number of supervision hours completed by the applicant: _____

Total number of individual supervision hours completed by the applicant: _____

Total number of group supervision hours completed by the applicant: _____

Date of supervision: _____ to _____.
(month / year) *(month / year)*

List all graduate degrees, credentials and/or state board issued licenses / certifications that qualified this individual to serve as a clinical addiction counselor supervisor: _____

_____

I affirm that the above information is true and correct to the best of my knowledge and belief.

Signature of professional colleague	Date *(month, day, year)*