



**For Official Use Only**

Approved:  Yes  No

Date: \_\_\_\_\_

**New Jersey Office of the Attorney General**  
Division of Consumer Affairs  
State Board of Marriage and Family Therapy Examiners  
Alcohol and Drug Counselor Committee  
124 Halsey Street, 6th Floor, P.O. Box 45040  
Newark, New Jersey 07101  
(973) 504-6582

**PROPOSED PLAN OF C.A.D.C. SUPERVISION**  
**(To be submitted by supervisor.)**  
**(N.J.A.C. 13:34C-6.3(m))**

Date: \_\_\_\_\_

C.A.D.C. name: \_\_\_\_\_

C.A.D.C. address: \_\_\_\_\_  
Street or P.O. Box City State ZIP code

Certification number: \_\_\_\_\_ Date certified: \_\_\_\_\_

**Supervisor's Information (Please print clearly.)**  
**(If the C.A.D.C. is supervised by more than one supervisor, submit a separate form for each supervisor.)**

Supervisor's name: \_\_\_\_\_  
Last name First name Middle initial

License number: \_\_\_\_\_ Date licensed: \_\_\_\_\_  
(List all license numbers)

College/University: \_\_\_\_\_ Graduated degree title: \_\_\_\_\_

Date awarded: \_\_\_\_\_ License or Application Number: \_\_\_\_\_

**Supervision credential (N.J.A.C. 13:34C-6.3(a)):**  
**Licensure of proposed supervisor: (Check all that apply.)**

- L.C.A.D.C.                       L.P.C.                                       L.M.F.T.
- Certified APN                       L.C.S.W.                                       Licensed Psychologist
- CCS Credential                       Yes  No
- Physician, A.S.A.M./A.B.A.M. Certified?                       Yes  No
- Psychiatrist, A.S.A.M./A.B.A.M. Certified?                       Yes  No

Has the Proposed Supervisor ever had a license restriction imposed which prohibited the supervision of others?  Yes  No

Has the Proposed Supervisor ever been disciplined by any professional licensing board?  Yes  No

**Practice/Agency Name and Location**  
**(If more than one location, submit a separate form for each location.)**

Name: \_\_\_\_\_  
Agency/Business

Address: \_\_\_\_\_  
Street or P.O. Box City State ZIP code

Telephone number: \_\_\_\_\_ E-mail contact: \_\_\_\_\_  
(include area code)

Web page: \_\_\_\_\_ Date supervision commenced: \_\_\_\_\_

C.A.D.C. job title: \_\_\_\_\_

Number of hours of individual supervision per week \_\_\_\_\_ Number of hours of group supervision per week \_\_\_\_\_

I certify that I have read and will comply with the statute, N.J.S.A. 45:2D-1 et seq., and the regulations at N.J.A.C. 13:34C related to the scope of practice, general obligations, client records, confidentiality and clinical supervision in this supervisory relationship and have reviewed the regulations with the C.A.D.C.

I understand that I am ultimately responsible for the treatment and welfare of the client.

As the supervisor, are you aware of any restriction on the supervisee's certification?  Yes  No

If "Yes," please detail restriction. \_\_\_\_\_

Do you have any other relationship with the C.A.D.C. (see N.J.A.C. 13:34C-6.3(i))?  Yes  No

If "Yes," please submit a written statement with details of that relationship.

**THE SUPERVISOR IS REQUIRED TO IMMEDIATELY NOTIFY THE ALCOHOL AND DRUG COUNSELOR COMMITTEE OF ANY CHANGES IN THE EMPLOYMENT OF EITHER THE C.A.D.C. OR THE SUPERVISOR.**

### **Certification**

I certify that all of the foregoing information provided herein is true and if any information provided by me is willfully false, I am subject to disciplinary action.

Supervisor's signature: \_\_\_\_\_