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

Schedule A
Supervisor's Forms

300 Hours of Supervised Practical Training

If you have been previously certified as an alcohol and drug counselor by an International Certification Reciprocity Consortium affiliated board, you may submit verification from the Addiction Professionals Certification Board of New Jersey in lieu of completing Schedule A.

Please put a check in the box next to the type of application you are submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

Supervisor(s) name: _____

You should send a photocopy of this page to **every** supervisor and/or agency that provided this training.

(All practicum hours must have been completed within the three-year period immediately preceding the submission of this application.)

Core functions of alcohol and drug counseling	Hours required	When completed (month/year)	Supervisor's signature
1. Screening	15 hours	_____	_____
2. Intake	15 hours	_____	_____
3. Orientation	15 hours	_____	_____
4. Assessment	15 hours	_____	_____
5. Treatment Planning	35 hours	_____	_____
6. Individual Counseling	35 hours	_____	_____
7. Group Counseling	35 hours	_____	_____
8. Family Counseling	30 hours	_____	_____
9. Case Management	20 hours	_____	_____
10. Crisis Intervention	15 hours	_____	_____
11. Client Education	15 hours	_____	_____
12. Referral	15 hours	_____	_____
13. Consultation	15 hours	_____	_____
14. Reports/Recordkeeping	25 hours	_____	_____

I hereby certify that the supervised hours listed above were completed as noted.

_____ _____
Applicant's signature Date

Documentation of 3,000 Hours of Related Work Experience Pursuant to N.J.A.C. 13:34C-2.3(b)

Please put a check in the box next to the type of application you are submitting.
☐ L.C.A.D.C. application ☐ C.A.D.C. application

Instructions: This form should be completed if you are applying for licensure as a clinical alcohol and drug counselor or for certification as an alcohol and drug counselor. You may make photocopies of this page. Your experience must be in a 12-core-function alcohol and drug treatment position. Experiential hours may go back only five years.

All positions being documented must be accompanied by:

- an official job description signed by your supervisor and program director
- a program description (brochure or flyer) signed by the program director
- each job must include one Supervisor Evaluation Form (included in this application)
- a current resume of your clinical supervisor
- your current resume (as the applicant).

Applicant's name: _____

Employer's name: _____

Employer's address: _____

Program director: _____

Name of supervisor(s): _____

Your job title: _____ Dates of employment: _____ to _____

Please put a check in the box next to the title of the position you held. ☐ Counselor ☐ Intern ☐ Trainee ☐ Volunteer

(Note: The number of hours indicated in the answers to questions number 2 and 3 must equal the total number of hours indicated in the answer to question number 1.)

1. How many hours of supervised experience in alcohol and drug counseling are you documenting? _____

2. Of the hours documented in question number 1, how many hours in **direct** (face-to-face) client counseling are you documenting?

_____

3. Of the hours documented in question number 1, how many were spent in all other core-function areas? _____

_____ _____
Applicant's signature Date

_____
Employer/ Supervisor's signature

Supervisor Information Form

Please put a check in the box next to the type of application the applicant is submitting.
☐ L.C.A.D.C. application ☐ C.A.D.C. application

Note to supervisor: The Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners believes that licensure and certification should be based on input from a variety of sources, including the observations of people who supervise the applicant. For this reason, each applicant is required to obtain an evaluation from a clinical supervisor. Your evaluation, among others, and data furnished by the applicant will be used in determining eligibility for licensure or certification. As this process can only be effective with careful and truthful reporting, all information gathered in the evaluation process is confidential.

Please return this form and the attached ratings to the address listed on page one. In the event that you cannot rate the applicant on the items, please indicate so, and return this form to the Committee.

The supervisor must submit a copy of his or her resume or a statement about his or her background with this evaluation.

Applicant's name: _____

Agency's name:_____

Agency's address: _____

Name of supervisor(s): _____

Title of supervisor(s): _____ Telephone number (include area code): _____

Length of time you have:

A. Known the applicant_____

B. Provided direct supervision of this applicant _____

Please complete:

I hereby certify that I have been in a position to directly supervise the above-named person's work. In my judgment, this applicant's eligibility and professional experience (check one) ☐ is ☐ is not consistent with licensure or certification standards as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners. The information that I am providing is my best judgment of the above-named person's capabilities to be: (check one)
☐ licensed as a clinical alcohol and drug counselor, or ☐ certified as an alcohol and drug counselor.

The type(s) of supervision I have used with this counselor include those checked below.

☐ Audio/video tapes ☐ Case discussions ☐ Group supervision ☐ One-way mirror observation
☐ Case presentations ☐ Individual supervision ☐ Telephone consultation ☐ Other

_____ _____
Supervisor's signature Date

Professional licensure, degrees or certifications: _____
☐ I am a Certified Clinical Supervisor

Supervisor Evaluation Form

Please put a check in the box next to the type of application the applicant is submitting.
☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

Evaluator's name: _____

Note: Please rate the applicant in each area using the following scale:

0 = No basis for judgment
1 = Inadequate
2 = Needs development
3 = Acceptable
4 = Good
5 = Outstanding

Area of knowledge, skills or competency

1) Communication
   a) Oral _____
   b) Written _____

2) Knowledge of Alcoholism/Drug Abuse
   a) Physiological _____
   b) Pharmacological _____
   c) Psychological _____

3) Evaluation and Client Assessment
   a) Knowledge of:
      i) Human growth and development _____
      ii) Family dynamics and interaction _____
      iii) Signs and symptoms of alcoholism and drug abuse _____
      iv) Signs and symptoms indicating referral for medical, psychological or other assessment _____
   b) Analytical skills:
      i) Assessing stages of alcoholism/abuse _____

Area of ethical standards

1) Orientation in all efforts towards a primary goal of recovery for the client and his or her family. _____

2) Respect for confidentiality of records, materials and communication concerning clients. _____

3) Respect for the client by maintaining an objective, nonpossessive professional relationship. _____

4) No discrimination among clients or professionals on the basis of race, color, creed, age, sex or sexual orientation. _____

5) Respect for the rights and views of other alcohol and/or drug workers and other professionals. _____

6) Respect for institutional policies and cooperation with management functions.
Initiative toward improving institutional policies and management functions. _____

7) Evidence of genuine interest in helping people with alcohol and/or drug problems and dedication to helping lead clients to methods of helping themselves as much as possible. _____

8) Willingness to access one's own personal and vocational strengths and limitations, biases and effectiveness. The ability and willingness to recognize when it is in the client's best interest to refer or release him or her to another individual or program. _____

9) Willingness to take personal responsibility for continued professional growth through further education or training. _____

10) Total commitment to providing the highest quality of care through both personal effort and the utilization of any other health professional or services which may assist the client in his or her recovery program. _____

Certification

I hereby certify that I have provided a minimum of _____ hours of face-to-face clinical supervision per month including _____ hours of individual supervision and _____ hours of group supervision.

_____ _____

Supervisor's signature Date

*** Additional comments may be made below.***

Self-Help Meeting Verification Form

Please put a check in the box next to the type of application you are submitting.

☐ L.C.A.D.C. application ☐ C.A.D.C. application

Applicant's name: _____

(Specified below are the minimum number of self-help meetings required for this application.)

Minimum Number of Meetings Required:

A.A. - 5 ALANON - 5 N.A. - 5 OTHER - 15

Date	A.A. location
1)	
2)	
3)	
4)	
5)	

Date	ALANON location
1)	
2)	
3)	
4)	
5)	

Date	N.A. location
1)	
2)	
3)	
4)	
5)	

Date	Name of other self-help groups (Can include additional A.A., ALANON, N.A. groups or other self-help groups.)
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

As required for licensure as a clinical alcohol and drug counselor or certification as an alcohol and drug counselor in the State of New Jersey, I certify that I have attended the meetings listed on this form.

_____ _____

Applicant's signature Date

As the applicant's supervisor, I certify that the applicant has provided documentation that he or she has attended the meetings listed above.

_____ _____

Supervisor's signature Date