STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF ALCOHOL AND DRUG COUNSELORS
PRACTICAL TRAINING

TO BE COMPLETED BY APPLICANT

APPLICANT: Complete the top portion and forward a copy to the individual(s) who supervised your practical training in alcohol and drug counseling.

Applicant's Name _____ Date of Birth: _____/_____/_____

Day Time Phone _____

Name of person providing verification of supervised practical training _____

Dates of practical training: from _____/_____/_____ to _____/_____/_____

TO BE COMPLETED BY SUPERVISOR ONLY

The applicant identified above completed practical training under my supervision in alcohol and drug counseling from _____/_____/_____ to _____/_____/_____.

Name and address of organization where work experience/internship was completed:

_____

Total hours of supervised practical training in alcohol and drug counseling completed _____.

Do you have any derogatory information regarding the competency or conduct of this individual?
YES ☐ **NO** ☐. If yes, please explain: _____

_____

_____

I certify that the above named applicant received a minimum of ten (10) hours of clinical training in each of the following core counseling functions: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, referral, report and record keeping, and consultation. **YES** ☐ **NO** ☐.

If no, please indicate below the Core Counseling functions not covered by at least 10 hours:

	Hours provided		Hours provided		Hours provided
☐ screening	_____	☐ assessment	_____	☐ case management	_____
☐ intake	_____	☐ treatment planning	_____	☐ crisis intervention	_____
☐ referral	_____	☐ report and record keeping	_____	☐ consultation	_____
☐ orientation	_____	☐ counseling	_____	☐ client education	_____

All of the statements contained herein are true and correct to the best of my knowledge and belief.

_____ _____
Name of Person Completing Form *Telephone Number*

_____ _____
Signature *Date*

This form must be returned directly by the supervisor to the following address:

Department of Public Health
ADC Licensure/Certification
410 Capitol Ave., MS **#12APP**
P.O. Box 340308
Hartford, CT 06134-0308