CERTIFIED CO-OCCURRING DISORDERS PROFESSIONAL-DIPLOMATE INSTRUCTIONS FOR COMPLETING THE "WORK EXPERIENCE VERIFICATION RECORD"

1. APPLICANT CONSENT TO RELEASE INFORMATION. Applicant completes this section. Applicant must sign and date form; giving permission for the supervisor to provide information and documentation regarding the applicant's work experience to ADAD. After completing, applicant gives this form to the supervisor.

2. CLINICAL SUPERVISOR INFORMATION AND CREDENTIALS. Clinical supervisor prints name, program unit where applicant worked, organization, address, phone numbers (day and evening), email, job title and check off all credentials/licenses.

3. APPLICANT WORK EXPERIENCE DOCUMENTATION.

   - Work Experience (Must be completed within the last 10 years)

     - 2000 hours of co-occurring disorder specific work experience.
     - 100 hours of face-to-face supervision with a minimum of 10 hours in the following Co-Occurring Disorder Domains:
       1) Screening and Assessment
       2) Crisis Prevention and Management
       3) Treatment and Recovery Planning
       4) Counseling
       5) Management and Coordination of Care
       6) Education of the Client, Their Support System, and Community
       7) Professional Responsibility
     - Remaining hours of supervision and experience can be completed in any domain as deemed appropriate by the applicant and clinical supervisor.

4. CLINICAL SUPERVISORS CERTIFICATION AND SIGNATURE. Clinical Supervisor will sign and date document certifying that the Work Experience Verification Record of the applicant is true to the best of his/her knowledge.

IF YOU HAVE ANY QUESTIONS RELATED TO THIS FORM, PLEASE CONTACT THE ADAD CERTIFICATION OFFICE AT 808-692-7518.

PLEASE COMPLETE THE WORK EXPERIENCE VERIFICATION RECORD AND FORWARD IT TO:

CERTIFICATION OFFICE
ALCOHOL AND DRUG ABUSE DIVISION
601 KAMOKILA BOULEVARD, ROOM 360
KAPOLEI, HAWAII 96707

CERTIFIED CO-OCCURRING DISORDERS PROFESSIONAL-DIPLOMATE
WORK EXPEREINCE VERIFICATION RECORD

APPLICANT CONSENT TO RELEASE INFORMATION	
** TO BE COMPLETED BY APPLICANT ** (PLEASE PRINT)	
APPLICANT NAME:	
HOME ADDRESS:	HOME TELEPHONE NO.:
BY MY SIGNATURE BELOW, I AM AUTHORIZING THE SUPERVISOR IDENTIFIED BELOW TO PROVIDE INFORMATION AND DOCUMENTATION TO THE STATE OF HAWAII, DEPARTMENT OF HEALTH, ALCOHOL AND DRUG ABUSE DIVISION (ADAD)	
APPLICANT SIGNATURE:	DATE:

INFORMATION AND INSTRUCTIONS TO CLINICAL SUPERVISOR: PLEASE COMPLETE THIS FORM WHICH REFELECTS YOUR KNOWLEDGE OF THE APPLICANT'S EDUCATION, WORK EXPERIENCE AND SUPERVISION WHILE EMPLOYED AT THE WORK SETTING INDICATED. BE SURE THAT THE APPLICANT HAS SIGNED THE ABOVE "APPLICANT CONSENT TO RELEASE INFORMATION" ALLOWING YOU TO MAKE AVAILABLE TO ADAD INFORMATIONAND DOCUMENTATION REGARDING HIS/HER WORK EXPERIENCE NEEDED TO MEET THE CERTIFICATION REQUIRMENTS.

CLINICAL SUPERVISOR INFORMATION AND CREDENTIALS	
** TO BE COMPLETED BY A CLINICAL SUPERVISOR ** (PLEASE PRINT)	
DO NOT COMPLETE THIS WORK EXPEREINCE VERIFICATION RECORD UNLESS THE RELEASE IS SIGNED	
CLINICAL SUPERVISOR'S NAME	PROGRAM UNIT WHERE APPLICANT WORKED
CLINICAL SUPERVISOR'S ORGANIZATION AND ADDRESS	CLINICAL SUPERVISOR'S PHONE NO. DAY: EVENING:
JOB TITLE OF CLINICAL SUPERVISOR	EMAIL ADDRESS:

CHECK ALL CREDENTIALS/LICENSES THAT VERIFY YOUR STATUS AS A QUALIFIED HEALTH PROFESSIONAL

☐ CSAC ☐ CCS ☐ CCDP ☐ LICENSED CLINICAL SOCIAL WORKER

☐ LICENSED PSYCHOLOGIST ☐ LICENSED PHYSICIAN ☐ LICENSED ADVANCED PRACTICE REGISTERED NURSE

__ LICENSED MARRIAGE & FAMILY THERAPIST __ LICENSED PROFESSIONAL MENTAL HEALTH COUNSELOR

IF YOU HAVE ANY QUESTIONS RELATED TO THIS FORM, PLEASE CONTACT ADAD CERTIFICATION OFFICE AT 808-692-7518.

WORK EXPERIENCE DOCUMENTATION (Completed within the last 10 years)

	WORK EXPERIENCE (Total of 2,000 hours)	**SUPERVISED WORK EXPERIENCE** (Total of 100 hours of supervision with a minimum of 10 hours in each domain)
Screening and Assessment:	_____ hours	_____ hours
Crisis Prevention and Management:	_____ hours	_____ hours
Treatment and Recovery Planning	_____ hours	_____ hours
Counseling:	_____ hours	_____ hours
Management and Coordination of Care:	_____ hours	_____ hours
Education of the Client, Their Support System, and Community:	_____ hours	_____ hours
Professional Responsibility:	_____ hours	_____ hours
TOTALS	_____ hours	_____ hours

CLINICAL SUPERVISOR'S CERTIFICATION AND SIGNATURE

I HAVE REVIEWED OUR ORGANIZATION'S RECORDS AND CERTIFY THAT THE INFORMATION PROVIDED ON THIS WORK EXPERIENCE VERIFICATION RECORD OF THE ABOVE-NAMED APPLICANT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF APPLICANT'S SUPERVISOR	DATE