CERTIFIED CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL
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 preceptor to provide information and documentation regarding the applicant's work experience to ADAD. After completing, applicant gives this form to the clinical supervisor.

2. CLINICAL SUPERVISOR INFORMATION AND CREDENTIALS. Clinical Supervisor prints name, program unit where applicant worked, organization, address, phone numbers (day and evening), job title and check off all credential/licenses. Clinical Supervisors must hold an active CSAC, CCJP, or CCS credential.

3. WORK EXPERIENCE DOCUMENTATION.

    - Work Experience:

        - Document the actual hours of work experience in each domain.

    - Supervised Work Experience:

        - Document the supervision hours provided in each domain. A minimum of ten hours of supervision is required in each domain.

        - Remaining hours of supervision, if any, can be completed in any domain as deemed appropriate by the applicant and supervisor.

4. CLINICAL SUPERVISORS CERTIFICATION AND SIGNATURE. Print name and job title and check each credential that applies. Sign and date the form, then complete the evaluation signing and dating that form where indicated. Clinical Supervisors must hold an active CSAC, CCJP, or CCS credential.

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 CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL
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 PRECEPTOR/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:

5. **INFORMATION AND INSTRUCTIONS TO SUPERVISOR:** PLEASE COMPLETE THIS FORM WHICH REFELECTS YOUR KNOWLEDGE OF THE APPLICANT'S WORK EXPERIENCE AND/OR SUPERVISION PROVIDED 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 INFORMATION AND DOCUMENTATION REGARDING HIS/HER WORK EXPERIENCE NEEDED TO MEET THE CERTIFICATION REQUIRMENTS. Clinical Supervisors must hold an active CSAC, CCJP, or CCS credential.

CLINICAL SUPERVISOR INFORMATION AND CERTIFICATION	
** TO BE COMPLETED BY 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 ☐ CCJP ☐ CCDP ☐ LICENSED CLINICAL SOCIAL WORKER ☐ LICENSED PSYCHOLOGIST ☐ LICENSED PHYSICIAN ☐ LICENSED ADVANCED PRACTICE REGISTERED NURSE	

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

WORK EXPERIENCE DOCUMENTATION –
Work Experience must be obtained within ten years of application

	WORK EXPERIENCE	**SUPERVISED WORK EXPERIENCE** (Minimum of 10 hours of supervision in each domain
Dynamics of Addiction and Criminal Behavior:	_____ hours	_____ hours
Legal, Ethical, and Professional Responsibility:	_____ hours	_____ hours
Criminal Justice System and Processes:	_____ hours	_____ hours
Clinical Evaluation: Screening and Assessment:	_____ hours	_____ hours
Treatment Planning:	_____ hours	_____ hours
Case Management, Mentoring, and Participant Supervision:	_____ hours	_____ hours
Counseling:	_____ hours	_____ hours
Documentation:	_____ 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 CLINICAL SUPERVISOR:	DATE:

CONFIDENTIAL EVALUATION

The following items are representative of the skills needed by a certified criminal justice addictions professional. Please evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the following scale:

1 Minimum Ability | 2 Below Average Ability | 3 Average Ability | 4 Above Average Ability | 5 Outstanding Ability | X Unknown or Not Observed

CLINICAL SKILLS/ABILITIES	EVALUATION (Circle One)	COMMENTS
Dynamics of Addiction and Criminal Behavior	1 2 3 4 5 X	
Criminal Justice System and Processes	1 2 3 4 5 X	
Clinical Evaluation: Screening and Assessment	1 2 3 4 5 X	
Treatment Planning	1 2 3 4 5 X	
Case Management, Monitoring and Participant Supervision	1 2 3 4 5 X	
Counseling	1 2 3 4 5 X	
Documentation	1 2 3 4 5 X	
SELF-EVALUATION: Ability to evaluate one's own shortcomings; accept guidance or suggestions (openness to the supervisory process)	1 2 3 4 5 X	
DECISION-MAKING: Ability to make decisions and initiate action with minimal or no supervision	1 2 3 4 5 X	
CONFIDENTIALITY: Ability to comply with State and Federal laws pertaining to client's rights and confidentiality	1 2 3 4 5 X	
ETHICS: Ability to comply with the Code of Ethics [HAR 11-177.1-33]	1 2 3 4 5 X	

SUPERVISOR CERTIFICATION

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN AND ON ANY ATTACHMENTS IS TRUE TO THE BEST OF MY KNOWLEDGE.	
SIGNATURE OF APPLICANT SUPERVISOR	DATE

PLEASE RETURN THIS EVALUATION ALONG WITH THE WORK EXPERIENCE VERIFICATION RECORD TO:

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