Wyoming Mental Health Professions Licensing Board

VERIFICATION AND EVALUATION OF SUPERVISED EXPERIENCE

FOR CERTIFIED ADDICTIONS PRACTITIONER BY EXPERIENCE

SUPERVISOR

IT IS VERY IMPORTANT THAT YOU READ AND COMPLY WITH THESE DIRECTIONS.

Your name has been submitted by the applicant as someone who has supervised their professional clinical experience. The Board, as well as the applicant, would appreciate you providing the information requested and returning this form directly to the Board at the above address. Please do not give the completed form to the applicant to be submitted to the Board. Please do not ask the applicant to complete any information on this form. The Board will not accept this information from the applicant or through the applicant's hands in any way. This information will be kept confidential by the Board, although the applicant may be informed of the number of hours reported. The form will not be reviewed unless all areas are completed. Incomplete forms will not be accepted and will be returned to the supervisor. Failure to return this form will affect the applicant's ability to become licensed in a timely manner.

Direct Client Contact - These hours are supervised work experience as a certified addictions practitioner assistant or equivalent in the field of addiction therapy as individual or group therapy. Do not include hours that are not related to the provision of addiction related services.

Supervision hours - Hours spent in either face to face or triadic supervision. Supervision must be provided as required in Chapter 18 of the Rules including provision at a ratio of 1 hour of supervision for 20 hours of direct client contact.

FOR EXPERIENCE COMPLETED IN WYOMING: The "From" date cannot be prior to the date the Supervision Agreement was approved by the Board after the issuance of the Provisional License to the supervisee.

FOR EXPERIENCE COMPLETED OUT-OF-STATE: The supervisor and supervision must meet the requirements of Chapter 18 of the Rules for the Board to consider the hours.

Supervisors need to track the hours and be able to provide documentation should the Application Review Committee request it.

Supervisors can only report the hours for which they provided supervision.

DO NOT include hours the supervisee worked under someone else.

If there was more than one supervisor working with the same supervisee, you must work with the other supervisor to report the hours so that the supervisee does not get double credit for their hours.

If you have any questions, please contact the Board Office at WyoMHPLB@wyo.gov, or (307) 777-3628

Mental Health Professions Licensing Board

2001 Capitol Ave, Room 127
Cheyenne WY 82002
Fax: (307) 777-3508
WyoMHPLB@wyo.gov

The SUPERVISOR must submit this form directly to the Board Office.

CAP VERIFICATION AND EVALUATION OF SUPERVISED EXPERIENCE

Applicant's Name:	Last / First / Middle Initial
Experience was gained at:	Business Name Street Address / Phone number City / State / Zip Code
Supervisee's Email address:	
Supervisor's Name:	Last / First / Middle Initial
Supervisor's Address: (If different from where experience was gained)	Business Name Street Address / Phone number City / State / Zip Code
Supervisor's Email address:	

If there are any questions or issues regarding your responses, we will communicate with you at this address.

Supervisor Licenses

List each license held during the time you supervised this applicant. In order to be considered a qualified clinical supervisor, you must have been independently licensed for at least (2) years with at least four (4) years of experience PRIOR to supervising the applicant. Report the date that your license was originally issued, and not the date that it was last renewed.

State	*License #*	*License Type*	*Issue Date*	*Expiration Date*	*Status (Active, Expired, Revoked)*

ADDICTIONS EXPERIENCE

From: _____ to _____ (mm/dd/yyyy to mm/dd/yyyy) *to "Present" is unacceptable

From date cannot be prior to approved Supervision Agreement date

Direct Client Contact Hours:_____ (ONLY related to the provisions of addiction services)

Describe the supervised work experience as a certified addictions practitioner assistant or equivalent in the field of addiction therapy:

CLINICAL SUPERVISION

Only individual and triadic supervision is reportable. Group supervision does not meet the requirements of the Rules

Individual face to face supervision was provided for a total of _____ hours.

Triadic face to face supervision was provided for a total of _____ hours.

Total face to face hours of supervision: _____

Describe the clinical supervision process used:

Evaluate the applicant on the following:	Unable to evaluate	Poor	Average	Above Average	Superior
Skill Level in the area of addictions					
Ability to establish and maintain good professional relations.					
Possession of emotional maturity & stability required for satisfactory work with clients and patients.					
Understanding of and adherence to approved standards of professional and ethical conduct.					
Personal character: honesty, integrity and general conduct.					
Reputation among colleagues as a professional.					
Capacity for professional growth and development.					
I would rate the applicant's overall performance under my supervision as:					
I would rate the applicant's competency to diagnose under supervision:					

Provide any additional information regarding the applicant which you consider relevant:

_____

_____

_____

_____

_____

- ▢ I recommend that the applicant be considered for licensing without reservation.
- ▢ I recommend that the applicant be considered for licensing with reservation as outlined above.
- ▢ I do not recommend that the applicant be considered for licensing as outlined above.

Please check one:

- ▢ **Supervision has been terminated and I am no longer providing supervision to the supervisee**
- ▢ **I continue to provide supervision to the supervisee.**

. By signing this form I certify that the hours reported on this form are hours that I supervised the applicant and do not reflect hours completed under the supervision of anyone else. The information provided in this document is fair and accurate in every respect.

_____ _____

Signature Date

The signed Verification and Evaluation of Supervised Experience may be e-mailed to WyoMHPLB@wyo.gov, faxed to (307) 777-3628, or mailed to the address provided on this form. You only need to submit via one method.