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