Wisconsin Department of Safety and Professional Services

Office Location: 4288 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

AFFIDAVIT REGARDING SUPERVISED EXPERIENCE FOR CLINICAL SUBSTANCE ABUSE COUNSELORS FORM INFORMATION AND INSTRUCTIONS

- Work experience requirements for a Clinical Substance Abuse Counselor (CSAC) credential are detailed in Wis. Admin. Code SPS 161.03(7).
- A **minimum** of 5,000 hours of work experience performing the practice dimensions (listed in the table below) is required.
- The 5,000 hours must be gathered within the 5 years immediately preceding the date you submit your application for a Clinical Substance Abuse Counselor credential.
- The 5,000 hours may include any work experience obtained as a requirement for your substance abuse counselor credential.

To ensure timely processing of Form 2749-CSAC, please be mindful of the following:

- You must complete and sign the "Applicant" section at the top of Page 1.
- Your supervisor should list the actual "From" and "To" supervision dates on the form. Supervisors should not write "to present" instead of a "To" date.
- Supervisors must have an active credential during the supervision period and meet the qualifications under Wis. Admin. Code § SPS 162.02. Any exceptions to the qualification requirements should be pre-approved by the Department before beginning to gather hours.
- If supervision under one supervisor ends, for example, if your supervisor leaves the agency, ask the supervisor to complete and submit the form for the hours he or she supervised even if you have not completed 5,000 hours of supervised work experience.

Questions can be submitted in LicensE (https://license.wi.gov). On the top toolbar select "Request Support" and complete and submit the online "Create New Ticket" form.

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Use this form to document clinical substance abuse counselor (CSAC) supervised experience. (To document substance abuse counselor, SAC, supervised experience, use form 2749-SAC.)

APPLICANT: You must complete and sign this "Applicant" section. Once signed, forward the form to your clinical supervisor to complete the "Supervisor" section of the form. Supervisor must upload completed form directly into LicensE.

Last Name	First Name	MI	Former/Maiden Name(s)

CSAC-IT credential number	Date CSAC application submitted	CSAC Application Number
	__ __/__ __/__ __ __ __	PAR-

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, print and sign form.)	**Applicant Signature Date**
	__ __/__ __/__ __ __ __

SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Supervision may be provided by an intermediate clinical supervisor or an independent clinical supervisor or a physician, licensed psychologist, professional counselor, marriage and family therapist, clinical social worker, advanced practice social worker, or independent social worker who practices as a substance abuse clinical supervisor. (Note: Proposed supervisors with temporary or training licenses require advance review and approval. **A credential holder acquiring supervised experience as a substance abuse counselor-in-training may not practice under the supervision of an individual holding a certificate as a clinical supervisor-in-training.)**

1.	I attest that I hold a certificate as a clinical supervisor-in-training. **IF YES, you may NOT serve as a supervisor to a substance abuse counselor-in-training to accrue supervised practice hours (unless you meet alternate criteria listed in Questions 2 or 4 below).**	☐ Yes ☐ No
2.	I, the supervisor named below, attest that I hold a **temporary or training** professional counselor, marriage and family therapist, clinical social worker, advanced practice social worker, or independent social worker credential. **IF YES, advance review and approval are required. Supervisor must upload this form résumé, and/or other evidence showing education, training, or experience in addiction treatment. You may also include a narrative statement explaining how you are knowledgeable in addiction treatment.**	☐ Yes ☐ No
3.	I, the supervisor named below, attest that I hold a current intermediate clinical supervisor or an independent clinical supervisor credential. **IF YES, skip Question 4. IF NO, complete Question 4.**	☐ Yes ☐ No
4.	**If NO to Question 3,** I, the supervisor named below, attest that I hold a **permanent, unlimited** physician, licensed psychologist, professional counselor, marriage and family therapist, clinical social worker, advanced practice social worker, or independent social worker credential **and** practice as a substance abuse clinical supervisor. **IF NO, advance review and approval are required. Supervisor must upload this form with a résumé and/or other evidence showing education, training, or experience in addiction treatment. You may also include a narrative statement explaining how you are knowledgeable in addiction treatment.**	☐ Yes ☐ No

Continued next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion continued.

Name of Agency where work experience was gained			
Address of Agency (number/street)	(city)	(state)	(zip code)

List the **Start Date and End Date** of supervised professional substance abuse counseling experience gathered at this facility with the supervisor and facility named below.

Start Date	__ __/__ __/__ __ __ __	**End Date**	__ __/__ __/__ __ __ __

NOTE: You **must** list an end date (not "to present.") If supervision is ongoing, the end date must be no later than supervisor signature date below.

Five thousand (5,000) hours of supervised work experience are required for CSAC certification. There are times when a trainee has multiple supervisors. **Please list and verify only the hours for which you personally supervised the above-named applicant**.

Review supervision dates entered on Page 1 and complete blank below for hours gathered during the time period specified.

Enter the number of hours of work experience gathered during the time period listed at the bottom of Page 1. This includes all work experience dimensions under Wis. Admin. Code § SPS 161.02(6). (See Wis. Admin. Code chs. SPS 160 and 162 for additional information.)	HOURS

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

I am a supervisor holding the credential named above and I have supervised the above-named applicant with individuals diagnosed with substance use disorders.

Supervisor Signature (If unable to provide a digital signature, print and sign form.)	**Supervisor Date**
	__ __/__ __/__ __ __ __
Supervisor Printed Name	**Phone Number**
	__ __ __- __ __ __- __ __ __ __

Supervisor Title	
Credential(s) held by Supervisor	
Supervisor Credential Number(s) (including numbers following the dash)	