Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

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

MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING AND SOCIAL WORK EXAMINING BOARD

AFFIDAVIT REGARDING SUPERVISED EXPERIENCE FOR SUBSTANCE ABUSE SPECIALTY AUTHORIZATION

(To be completed by supervisor only)

Provided the supervisor has knowledge in psychopharmacology and addiction treatment, qualified supervisors include: a licensed marriage and family therapist; a licensed professional counselor; a licensed clinical social worker; a licensed psychologist; a licensed physician; a clinical supervisor as defined by Wis. Admin. Code § SPS 160.02(7); or another individual approved in ***advance*** of the supervising by the Board [Wis. Admin. Code § MPSW 1.09(4)].

APPLICANT: Complete this section and forward to your supervisor. Form must be returned directly from the supervisor to the Department.

Profession (Check one according to social work level.)

☐ Social Work Training Certificate ☐ Social Worker ☐ Social Worker-Temp

Application Number

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

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. I hereby authorize the school named below to provide the Department with the information requested below.

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

SUPERVISOR: Complete section below and return form directly to the department using the LicensE Third-Party* 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.)

Supervisor's Name:

Supervisor's Credential Number: _____-___

Profession Supervisor is Credentialed:

Name of Agency where work experience was gained:

Address of Agency where supervised experience was gained: (city, state, zip code)

Beginning and ending dates of this supervised professional substance abuse counseling experience:

From: __/__/____ To: __/__/____

Continued on next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion, continued.

I am a supervisor qualified as defined by Wis. Admin. Code § MPSW 1.09(4) and I am knowledgeable in psychopharmacology and addiction treatment.

Bachelor's Degree (Social Worker, Social Worker-Temp, Social Work Training Certificate)**:**

☐ I have supervised the above applicant for at least 1,000 hours of face-to-face client counseling experience with individuals diagnosed with substance use disorders.

(Signature of current supervisor is acceptable even if experience was completed in previous place of employment.)

I swear that the foregoing information is true and accurate.

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.

	__/__/____
Signature (If unable to provide a digital signature, print and sign form.)	**Date**
	___-___-____
Title	**Phone**