Wisconsin Department of Safety and Professional Services

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

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

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

EMPLOYMENT/VOLUNTEER VERIFICATION FORM FOR SUPERVISED SUBSTANCE ABUSE COUNSELOR PRACTICE

Please note, according to Wis. Stat. § 440.88(4) a SAC-IT certification may only be renewed twice. The supervised work experience required for a SAC certification according to Wis. Admin. Code § SPS 161.02(6) must be completed within the timeframe of the original certification plus two (2) renewal periods.

APPLICANT: Complete this section and forward the form to your clinical supervisor to complete the remainder of the form. Supervisor must upload completed form directly into LicensE. (Supervisor instructions are below.)

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

I am in a position or have an offer for a position, internship, practicum, or an agreement authorizing volunteer hours at an agency providing substance use disorder treatment per Wis. Admin. Code § SPS 161.01(5).

- The supervisor may not permit a supervisee to engage in any substance abuse practice that the supervisee cannot competently perform.
- The supervisor shall not permit a supervisee to engage in any practice that the supervisor cannot competently supervise.
- All supervisors shall be legally and ethically responsible for the supervised activities of the substance use disorder professional supervisee. Supervisors shall be available or make appropriate provision for emergency consultation and intervention. Supervisors shall be able to interrupt or stop the supervisee from practicing in given cases or recommend to the supervisee's employer that the employer interrupt or stop the supervisee from practicing in given cases, and to terminate the supervised relationship, if necessary.

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.)	**Date**	**Application Number**
	__/__/____	

CLINICAL SUPERVISOR OF SUBSTANCE ABUSE COUNSELORS-IN-TRAINING: 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.)

The clinical supervisor shall provide supervision as required per Wis. Admin. Code § SPS 162.01.

Name of Employer	
Supervisor's Printed Name	

Continued next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion, continued.

Supervisor's Credential Number: ☐☐☐☐☐☐ - ☐☐☐ Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Credential held by Supervisor: _____

_____ _____ _____ _____

Facility Address (number/street) (city) (state) (zip code)

Clinical 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, the supervisor named above, 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 above, 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 with 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 above, attest that I hold a current intermediate clinical supervisor or an independent clinical supervisor. **IF YES, skip Question 4**. **IF NO, complete Question 4.**	☐ **Yes** ☐ **No**
4.	**If no to Question 3,** I, the supervisor named above, 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 with 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**

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.

Supervisor's Signature (If unable to provide a digital signature, please print and sign form.)	**Date**
	☐☐/☐☐/☐☐☐☐