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/
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DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

AFFIDAVIT REGARDING SUPERVISORY EXPERIENCE FOR INTERMEDIATE or INDEPENDENT CLINICAL SUPERVISOR

(Must be completed by supervisor only.)

APPLICANT: Complete this section and forward it to your clinical supervisor. Form must be returned directly from the supervisor to the Department.			
Last Name:	**First Name:**	**MI:**	**Former / Maiden Name(s):**

Application Number:	**Date of Birth:**
	__ __ / __ __ / __ __ __ __

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.

Signature of Applicant: (If unable to provide a digital signature print and sign form.)	**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.)

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

Supervisor's Printed Name:	
Supervisor's Credential Number:	
Credential Held by Supervisor:	

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

From: __ __ / __ __ / __ __ __ __ **To:** __ __ / __ __ / __ __ __ __

Continued next page.

Wisconsin Department of Safety and Professional Services

Supervisor completion continued.

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.

I attest that the foregoing information is true and accurate. I am a supervisor holding the credential named above and I have supervised the above applicant for one (1) year of clinical supervisory experience as a supervisor-in-training or intermediate supervisor within the last five (5) years; the candidate for licensure has met the requirements of Wis. Admin. Code § SPS 161.05(4).

(Signature of a current supervisor is acceptable, even if the experience was completed at a previous place of employment.)

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

Title:	**Supervisor's Daytime Phone Number:**
	___ - ___ - ____