 Mental Health and Recovery Services

Authority and Quality Improvement Services

**SUD Counselor** Supervision Reporting Form

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| Form Type  NEW  INFORMATION UPDATE \*Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to AQIS/MCST. |
| Registered Supervisee Information (select all that apply).  County Employee  CA Consortium of Addiction Programs & Professionals [CCAPP]  or Addiction Counselor Certification Board of CA [ACCBC] Contract Employee CA Association of DUI Treatment Programs [CADTP]  Name:  Registration Type: Choose an item. Registration #:    Phone:  Email:  Program/Clinic:  Service Chief/Program Director: |
| Certified/Licensed Supervisor Information  Name:  Certified/License Type: Choose an item. Certification/License #:  Phone  Email: Program/Clinic:  Service Chief/Program Director: |
| Supervision Term  Start Date:  End Date:   |  | | --- | | If terminating supervision, complete this section:  Reason for termination: Change of Supervisor Certified Termination of Employment Other   * If changing supervisor, additionally submit required document(s) for new supervisor * If certified, date of promotion per HR: * If terminating employment, date of termination: * If other, please specify: |   SUPERVISOR RECCOMENDATIONS:   * Supervisor must be certified or a licensed provider. * Possess a current and active certification/license. * Weekly Supervision is recommended until the supervisee is certified. * Supervisors are to stay current with the CCAAPP, ACCBC and CADTP requirements. * It is the responsibility of the direct supervisor to ensure the registered staff meets the CCAPP, ACCBC or CADTP requirements. * Supervision shall be provided and documented for ALL registered/waivered employees, interns, and volunteers. If supervision is not provided the individual is prohibited from providing and billing services. |
| I certify that I understand the responsibilities regarding supervision and that the supervision provided meets the requirements as specified by the certifying organization. I attest that the information submitted on this form is true and correct:  Registered Supervisee Signature Date    Certified/Licensed Supervisor Signature Date |

\*Please complete in full and submit to: [AQISManagedCare@ochca.com](mailto:AQISManagedCare@ochca.com) Subject Line: Clinical Supervision. For questions, please contact AQIS main line: 714-834-5601.