Mental Health and Recovery Services
Quality Management Services

SUD Counselor Supervision Reporting Form

Form Type

☐NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to QMS/MCST.

Registered Supervisee Information (select all that apply).

☐County Employee or ☐Contract Employee

☐ Individual Supervision ☐Group Supervision ☐ Both-2 CSRFs, if different supervisors

☐CA Consortium of Addiction Programs & Professionals [CCAPP] ☐Addiction Counselor Certification Board of CA [ACCBC] ☐CA Association of DUI Treatment Programs [CADTP]

Name:

Registration Type: Registration Type Registration #:

Phone: Email:

Program/Clinic:

Service Chief/Program Director:

Certified/Licensed Supervisor Information

Name:

Certified/License Type: Certified/Licensed Type 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 RECOMMENDATIONS: ☑ 2 SUD CSRFs, if there are multiple supervisors (i.e. group & individual)

- 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 Subject Line: Clinical Supervision. For questions, please contact QMS main line: 714-834-5601.

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SUD Counselor Supervisor Information

Date:

Name of Primary Counselor Supervisor:

List of **All** Current Supervisees

Name(s) of Current Supervisee(s)	Type of Supervision	Program Name	Supervisee Classification
Example: Jane Doe	☒ Group ☐ Individual	SUD: Westminster/ART	RAC
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		
	☐ Group ☐ Individual		

***** Reminder: If clinical supervision is terminated for any reason, a CSRF with the end date is required.**

*Please complete in full and submit to: AQISManagedCare@ochca.com. For questions, please contact QMS main line: 714-834-5601.