Addiction Professionals of South Carolina Clinical Supervision Plan

Name of Applicant: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ Email: _____

In-process Dates: Start _____ to End _____

Certification receiving supervision for: ADC ☐ AADC ☐ CS ☐

Clinical Supervisor Information

Name of Supervisor(s): _____

Name of Agency:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ Email: _____

License or Certification Type	License or Certification Number	Expiration Date

Plan for Supervision

I, _____ will provide clinical supervision of substance use counseling connected to the domains to _____. Supervision will begin _____(month/year) and will end on approximately _____(month/year). I will adhere to the guidelines set forth by the certification commission of Addiction Professionals of South Carolina.

_____ _____

Signature of Supervisor Date

_____ _____

Signature of In-process Candidate Date