STATE BOARD OF EXAMINERS OF ALCOHOLISM AND DRUG ABUSE COUNSELORS
Arkansas Department of Health
4815 W Markham, Box 42A
Little Rock, AR 72205

Verification of Supervision

I _____, hereby attest that I have completed a minimum of three (3) years or six thousand (6,000) hours of supervised experience providing counseling services to persons with addiction problems.

I understand that a Clinical Supervisor, approved by the Board of Examiners of Alcoholism and Drug Abuse Counselors, will verify my supervised experience based on the documentation presented to the SBEADAC.

_____ _____
Signature of Applicant **Signature – SBEADAC Board Member**

_____ _____
Date **Date**

I, _____ _____
Name Credentials
have been the supervisor of:_____
from the time frame of:_____.
Her/his duties consisted of:_____
_____
_____
_____
_____
_____
_____
_____
_____

Signed:_____ Date:_____