MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

MBSACC

CLINICAL SUPERVISOR EVALUATION FORM

CONFIDENTIAL

TO BE COM	PLETED BY APPLICANT
APPLICANT'S NAME: (PLEASE PRINT)	DATE:
I authorize the Massachusetts Board of Substance A my work and counseling skills from the evaluator lis	Abuse Counselor Certification to seek additional information about sted below.
PRINT NAME OF CLINICAL SUPERVISOR I hereby waive my right to inspect this evaluation fo connection with my application for Certification.	APPLICANT'S SIGNATURE orm and any subsequent information provided by the evaluator in
	APPLICANT'S SIGNATURE

To the Clinical Supervisor:

The individual named above is applying to the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) for certification as a substance abuse counselor (CAC, CADC, or CADC-II). The information requested from you is an essential part of the Board's evaluation of the competence of this applicant, and this completed form must be on file before the application can be reviewed and processed.

The Board believes that your evaluation from direct observation and supervision of the applicant's work will contribute to a more complete and accurate impression of the knowledge and skill of the applicant. The Board appreciates your accurate and truthful reporting. This form is considered by the Board to be **confidential**. As Supervisor, you may keep a photocopy of this evaluation for your files, but you must **not** provide a copy of this form, nor disclose its contents, to the applicant. You must mail it directly back to MBSACC. Failure to comply with this directive could void the entire application. MBSACC thanks you for your cooperation.

CLINICAL SUPERVISOR EVALUATION FOR	RM PART – A
SUPERVISOR'S NAME	SUPERVISOR'S JOB TITLE
CURRENT AGENCY NAME & ADDRESS	
()	
AGENCY PHONE # (PLEASE INCLUDE AREA CODE)	HIGHEST DEGREE HELD
STATE LINCENSE(S)/ CERTIFICATIONS HELD	
RELATIONSHIP TO APPLICANT (PLEASE CHECK AS MA	ANY AS APPLY):
☐ CONSULTANT ☐ PAST SUPER	·
☐ PRESENT SUPERVISOR ☐ OTHER (PLEA	SE SPECIF I)
ACENCY WILEDE SUDEDVISION OCCUDED DUEASE	PINICITIDE ADDDECC)
AGENCY WHERE SUPERVISION OCCURRED (PLEASE	CINCLUDE ADDRESS)
· ·	·
WAS THIS AGENCY LICENSED? Q Y Q N AS A	SUBSTANCE ABUSE TREATMENT AGENCY?: □ Y □ N
AGENCY WHERE SUPERVISION OCCURRED (PLEASE) WAS THIS AGENCY LICENSED? Y N AS A RESTRUCTORY OF THE SUBSTANCE ABUSE TREATMENT, PLEASE S.	SUBSTANCE ABUSE TREATMENT AGENCY?: □ Y □ N
WAS THIS AGENCY LICENSED? Q Y Q N AS A	SUBSTANCE ABUSE TREATMENT AGENCY?: □ Y □ N
WAS THIS AGENCY LICENSED? \(\begin{aligned} \Pi & N & AS A \\ \Pi & NOT SUBSTANCE ABUSE TREATMENT, PLEASE S. \\\ \ext{PLASE S.} \\ P	SUBSTANCE ABUSE TREATMENT AGENCY?: □ Y □ N
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION	SUBSTANCE ABUSE TREATMENT AGENCY?: Y N PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION	SUBSTANCE ABUSE TREATMENT AGENCY?: Y N PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION
WAS THIS AGENCY LICENSED? YN AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO:	SUBSTANCE ABUSE TREATMENT AGENCY?: Y N PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: TO: MONTH/YEAR	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED:
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: MONTH/YEAR	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED:
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED: HOURS PER WEEK FOR PERIOD LISTED ABOVE:
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: MONTH/YEAR TO: NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED AVERAGE NUMBER OF HOURS APPLICANT WORKER	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK:
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: MONTH/ YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED OF AVERAGE NUMBER OF HOURS APPLICANT WORKER TOTAL NUMBER OF HOURS PER WEEK IN DIRECT OF	SUBSTANCE ABUSE TREATMENT AGENCY?: Y N PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION PED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING:
WAS THIS AGENCY LICENSED? Q Y Q N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURRED TO: MONTH/YEAR TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED TO AVERAGE NUMBER OF HOURS APPLICANT WORKED TO NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENTAGE.	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION PED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: T IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.)
WAS THIS AGENCY LICENSED? Y N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: MONTH/YEAR TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED SUPERVISE	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION PED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: T IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.)
WAS THIS AGENCY LICENSED? Y N AS A SET NOT SUBSTANCE ABUSE TREATMENT, PLEASE SET NOT SUBSTANCE ABUSE TREATMENT, PLEASE SET NOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURRED TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED OF AVERAGE NUMBER OF HOURS APPLICANT WORKED TO NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENSOR WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASE AVERAGE NUMBER OF HOURS PER WEEK OF SUBSTANCES.	SUBSTANCE ABUSE TREATMENT AGENCY?: Y NPECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: IT IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.) E LOAD?
WAS THIS AGENCY LICENSED? Y N AS A SET OF THE APPLICANT WORK OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURRED TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED OF AVERAGE NUMBER OF HOURS APPLICANT WORKED TO NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENSOR WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASE AVERAGE NUMBER OF HOURS PER WEEK OF SUBSENTHE FOLLOWING AREAS:	SUBSTANCE ABUSE TREATMENT AGENCY?: Y NPECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: IT IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.) E LOAD?
WAS THIS AGENCY LICENSED? Y N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. YOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURRED TO: MONTH/YEAR TO: MONTH/YEAR TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED TO NOT INCLUDE HOURS PER WEEK IN DIRECT OF NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENSOR WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASINAL AVERAGE NUMBER OF HOURS PER WEEK OF SUBSING THE FOLLOWING AREAS: INDIVIDUAL COUNSELING GROUP COUNSELING	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION PED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: LIENT SUBSTANCE ABUSE COUNSELING: IT IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.) E LOAD? TANCE ABUSE COUNSELING PROVIDED FAMILY/ SIGNIFICANT OTHER COUNSELING
WAS THIS AGENCY LICENSED? Y N AS A REPORT OF SUBSTANCE ABUSE TREATMENT, PLEASE S. FOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURR FROM: TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED OF THE APPLICANT WORKER FOTAL NUMBER OF HOURS APPLICANT WORKER FOTAL NUMBER OF HOURS PER WEEK IN DIRECT OF NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENSON ON THE FOLLOWING AREAS: INDIVIDUAL COUNSELING GROUP COUNSELING PERCENTAGE OF TIME SPENT IN THE FOLLOWING OF THE SPENT IN THE FOLLOWING OF TIME SPENT IN THE SPENT IN TH	SUBSTANCE ABUSE TREATMENT AGENCY?: PECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION PED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: T IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.) E LOAD? STANCE ABUSE COUNSELING PROVIDED FAMILY/SIGNIFICANT OTHER COUNSELING CASELOAD AREAS:
WAS THIS AGENCY LICENSED? Q Y Q N AS A SET NOT SUBSTANCE ABUSE TREATMENT, PLEASE SET NOT SUBSTANCE ABUSE TREATMENT, PLEASE SET NOUR POSITION AT TIME OF SUPERVISION SUPERVISION OF THE APPLICANT'S WORK OCCURRED TO: MONTH/YEAR NUMBER OF DIRECT (FACE-TO-FACE) SUPERVISED OF AVERAGE NUMBER OF HOURS APPLICANT WORKED TO THE NUMBER OF HOURS PER WEEK IN DIRECT COO NOT INCLUDE HOURS THAT ARE NOT SPECIFICALLY SPENSE WHAT IS/WAS THE SIZE OF THE APPLICANT'S CASE AVERAGE NUMBER OF HOURS PER WEEK OF SUBSENT THE FOLLOWING AREAS:	SUBSTANCE ABUSE TREATMENT AGENCY?: Y NPECIFY (BELOW) TYPE OF LICENSED AGENCY: APPLICANT'S POSITION AT TIME OF SUPERVISION RED: HOURS PER WEEK FOR PERIOD LISTED ABOVE: D PER WEEK: CLIENT SUBSTANCE ABUSE COUNSELING: T IN COUNSELING (I.E., STAFF MEETINGS, TRAININGS, ETC.) E LOAD? STANCE ABUSE COUNSELING PROVIDED FAMILY/SIGNIFICANT OTHER COUNSELING CASELOAD AREAS:

CLINICAL SUPERVISOR EVALUATION FORM	PART – B –
N THE LINES BELOW, PLEASE PROVIDE A BRIEF DESCRIPTION OF THE APPLICANT'S PRIMAR RESPONSIBLITIES AS AN ALCOHOL/DRUG ABUSE COUNSELOR AT THE TIME OF SUPERVISIO	
DESCRIBE BELOW THE PROCEDURE USED IN SUPERVISION WITH THE APPLICANT. YOUR OF THIS PORTION ARE CONSIDERED VERY IMPORTANT. PLEASE COMPLETE THIS SECTION CA	
PAGE 3	

O = NO BASIS FOR JUDGEMENT

SCORING SCALE:

4 = ABOVE AVERAGE

PLEASE READ THE STATEMENTS BELOW WHICH DESCRIBE VARIOUS SKILLS NEEDED BY A SUBSTANCE ABUSE COUNSELOR. RATE THE APPLICANT'S ABILITY USING THE FOLLOWING SCALE, AND PLACE AN APPROPRIATE NUMBER VALUE ON THE BLANK TO THE RIGHT OF EACH STATEMENT.

2 = NEEDS IMPROVEMENT

		1 = INADEQUATE	3 = COMPETENT	5 = OUTSTANDING		
I.	SC	CREENING –				
	1.	EVALUATE PSYCHOLOGICAL, SOCIA ALCOHOL AND OTHER DRUG ABUSE		GNS AND SYSMPTOMS OF		
	2.	DETERMINE THE CLIENT'S APPROPE	PIATENESS FOR ADMISSION	OR REFERRAL.		
	3.	DETERMINE THE CLIENT'S ELIGIBILI	TY FOR ADMISSION OR REI	FERRAL		
	4.	IDENTIFY ANY COEXISTING CONDITI ETC.) THAT INDICATE NEED FOR AD AND/OTR SERVICES.				
	5.	ADHERE TO APPLICABLE LAWS, REG GOVERNING ALCOHOL AND OTHER		POLICIES		
II.	IN'	TAKE –				
	1.	COMPLETE REQUIRED DOCUMENTS	FOR ADMISSION TO THE P	ROGRAM.		
	2.	COMPLETE REQUIRED DOCUMENTS APPROPRIATENESS.	FOR PROGRAM ELIGIBILITY	Y AND		
	3.	OBTAIN APPROPRIATELY SIGNED CO OR PROVIDING INFORMATION TO OU CLIENT CONFIDENTIALITY AND RIGH	ITSIDE SOURCES IN ORDER			
III.	OF	ORIENTATION –				
	1.	PROVIDE AN OVERVIEW TO THE CLI AND OBJECTIVES FOR CLIENT CARE		RAM GOALS		
	2.	PROVIDE AN OVERVIEW TO THE CLI AND CLIENT OBLIGATIONS AND RIGI		RAM RULES		
	3.	PROVIDE AN OVERVIEW TO THE CLI	ENT OF PROGRAM OPERAT	IONS.		
IV.	AS	SSESSMENT –				
	1.	GATHER RELEVANT HISTORY FROM LIMITED TO, ALCOHOL AND OTHER INTERVIEW TECHNIQUES.				
	2.	IDENTIFY METHODS AND PROCEDUI INFORMATION FROM SIGNIFICANT S AND OTHER DRUG ABUSE AND PSYC	OURCES REGARDING CLIE			
	3.	IDENTIFY APPROPRIATE ASSESSME	NT TOOLS.			
	4.	EXPLAIN TO THE CLIENT THE RATIO TECHINIQUES IN ORDER TO FACILIT		SESSMENT		
	5.	DEVELOP A DIAGNOSTIC EVALUATION ANY COEXISTING CONDITIONS BASE ORDER TO PROVIDE AND INTEGRATION THE CLIENT'S STRENGTHS, WEA	ED ON THE RESULTS OF AL ED APPROACH TO TREATM	L ASSESSMENTS IN ENT PLANNING BASED		

CLIN.	ICA	L SUPERVISOR EVALUATION FORM	PART – C
V.	TR	EATMENT PLANNING –	
	1.	EXPLAIN ASSESSMENT RESULTS TO THE CLIENT IN AN UNDERSTANDABLE MANNER.	
	2.	IDENTIFY AND RANK PROBLEMS BASED ON INDIVIDUAL CLIENT NEEDS IN THE WRITTEN TREATMENT PLAN.	
	3.	FORMULATE AGREED-UPON IMMEDIATE AND LONG-TERM GOALS USING BEHAVIORAL TERMS IN THE WRITTEN TREATMENT PLAN.	
	4.	IDENTIFY THE TREATMENT METHODS AND RESOURCES TO BE UTILIZED AS APPROPRIATE FOR THE INDIVIDUAL CLIENT.	
VI.	CC	DUNSELING –	
	1.	SELECT THE COUNSELING THEORY(IES) THAT APPLY(IES).	
	2.	APPLY TECHNIQUES TO ASSIST THE CLIENT, GROUP, AND/OR FAMILY IN EXPLORING PROBLEMS.	
	3.	APPLY TECHNIQUE(S) TO ASSIST THE CLIENT, GROUP, AND/OR FAMILY IN EXAMINING THE CLIENT'S BEHAVIOR, ATTITUDE, AND/OR FEELINGS IF APPROPRIATE IN THE TREATMENT SETTING.	
	4.	INDIVIDUALIZE COUNSELING IN ACCORDANCE WITH CULTURAL, GENDER, AND LIFESTYLE DIFFERENCES.	
	5.	INTERACT WITH THE CLIENT IN AN APPROPRIATE THERAPEUTIC MANNER.	
	6.	ELICIT SOLUTIONS AND DECISIONS FROM THE CLIENT.	
VII.	. CASE MANAGEMENT –		
	1.	COORDINATE SERVICES FOR CLIENT CARE.	
	2.	EXPLAIN THE RATIONALE OF CASE MANAGEMENT ACTIVITIES TO THE CLIENT.	
VIII	. CR	PISIS INTERVENTION –	
	1.	RECOGNIZE THE ELEMENTS OF THE CLIENT CRISIS.	
	2.	IMPLEMENT AN IMMEDIATE COURSE OF ACTION APPROPRIATE TO THE CLIENT.	
	3.	ENHANCE OVERALL TREATMENT BY UTILIZING CIRSIS EVENTS.	
IX.	CL	IENT EDUCATION –	
	1.	PRSENT RELEVANT ALCOHOL AND OTHER DRUGE USE/ABUSE INFORMATION TO THE CLIENT THROUGH FORMAL AND/OR INFORMAL PROCESSES.	
	2.	PRESENT INFORMATION ABOUT AVAILABLE ALCOHOL AND OTHER DRUG SERVICES AND RESOURCES.	
Χ.	RE	FERRAL –	
	1.	IDENTIFY NEEDS AND/OR PROBLEMS THAT THE AGENCY AND/OR COUNSELOR CANNOT MEET.	
	2.	EXPLAIN THE RATIONALE FOR THE REFERRAL TO THE CLIENT.	
	3.	MATCH CLIENT NEEDS AND/OR PROBLEMS TO APPROPRIATE RESOOURCES.	
	4.	ADHERE TO APPLICABLE LAWS, REGULATIONS, AND AGENCY POLICIES COVERING PROCEDURES RELATED TO THE PROTECTION OF THE CLIENT'S CONFIDENTIALITY.	
	5.	ASSIST THE CLIENT IN UTILIZING THE SUPPORT SYSTEMS AND COMMUNITY RESOURCES AVAILABLE.	

CLINICAL SUPERVISOR EVALUATION FORM			
XI. REPORT AND RECORD KEEPING –			
1. PREPARE REPORTS AND RELEVANT RECORD INFORMATION TO FACILITATE THE CONTINUE			
2. CHART ONGOING INFORMATION PERTAINING	TO THE CLIENT.		
3. UTILIZE RELEVANT INFORMATION FROMWRIT	TTEN DOCUMENTS FOR CLIENT CARE		
XII. CONSULTATION WITH OTHER PROFESSIONALS –			
 RECOGNIZE ISSUES THAT ARE BEYOND THE KNOWLEDGE AND/OR SKILL 	COUNSELOR'S BASE OF		
2. CONSULT WITH APPROPRIATE RESOURCES T OF EFFECTIVE TREATMENT SERVICES	O INSURE THE PROVISION		
3. ADHERE TO APPLICABLE LAWS, REGULATION GOVERNING THE DISCLOSURE OF CLIENT ID.			
4. EXPLAIN THE RATIONALE FOR THE CONSULT	TATION TO THE CLIENT.		
CLINICAL SUPERVISOR EVALUATION FORM	PART – D –		
PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE C	COUNSELOR –		
COMMENTS AND/OR ADDITIONAL INFORMATION Y	YOU FEEL MAY BE PERTINENT –		
	I CERTIFY THAT I WAS EMPLOYED AS A SUPERVISOR OF THE APPLICANT NOTED BELOW BY THE AGENCY ALSO NOTED BELOW AND WAS, THEREFORE, IN A POSITION TO DIRECTLY OBSERVE		
THE APPLICANT'S WORK AT THAT AGENCY.			
APPLICANT'S NAME (PLEASE PRINT)	AGENCY NAME (PLEASE PRINT)		
SUPERVISOR'S NAME (PLEASE PRINT)	SUPERVISOR'S SIGNATURE		
	DATE		

PAGE 6

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES (PLEASE CHECK ONLY ONE STATEMENT).			
I RECOMMEND THIS APPLICANT FOR CERTIFICATION.			
I HAVE SOME RESERVATIONS IN RECOMMENDING THIS APPLICANT.			
I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION.			
THE SUPERVISOR COMPLETING THIS EVALUATION MUST READ AND SIGN THE FOLLOWING STATEMENT:			
I ATTEST THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED IN THIS EVALUATION FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.			
SUPERVISOR'S NAME (PLEASE PRINT HERE)			
SUPERVISOR'S SIGNATURE			
SUPERVISOR'S JOB TITLE DATE			

THIS CLINICAL SUPERVISOR EVALUATION FORM IS CONFIDENTIAL.

THE APPLICANT HAS WAIVED HIS/HER RIGHT TO VIEW ITS CONTENTS.

THE SUPERVISOR MAY MAKE A PHOTOCOPY OF THIS FORM FOR HIS/HER RECORDS, BUT NO COPY MAY BE PROVIDED TO THE APPLICANT, NOR SHOULD THE APPLICANT BE ALLOWED TO VIEW ITS CONTENTS.

PLEASE COMPLETE AND SIGN THIS FORM, AND MAIL IT DIRECTLY BACK TO:

MBSACC

560 LINCOLN STREET P.O. BOX 7070 WORCESTER, MA 01605

AN APPLICATION IS CONSIDERED INCOMPLETE WITHOUT THIS FORM, AND, IN MOST INSTANCES, MUST BE POSTMARKED BY A CERTAIN DEADLINE DATE. PLEASE CONFIRM WITH THE APPLICANT THE DEADLINE DATE BY WHICH THIS EVALUATION FORM MUST BE POSTMARKED, AND POSTMARK THIS FORM ON OR BEFORE THAT DATE. THANK YOU FOR YOUR COOPERATION.