CERTIFIED CLINICAL SUPERVISOR RELEASE FORM

I, ____________________________, grant Indiana Association of Addiction Professionals (IAAP) permission to post the following information about myself on their organization website for the purpose of supervisory locator.

NAME: ________________________________________________________________

CREDENTIALS: ________________________________________________________

BUSINESS NAME: ______________________________________________________

BUSINESS ADDRESS: ___________________________________________________

_______________________________________________________________________

CITY: ________________________________________________________________

STATE/ZIP CODE: _____________________________

EMAIL: _______________________________________________________________

OFFICE PHONE: ______________________________

CELL PHONE: _______________________________

FAX: ________________________________________

SIGNATURE: __________________________________ DATE: ________________