



The Indiana Association for Addiction Professionals

IAAP Central Office  
PO Box 24167  
Indianapolis, IN 46224  
317-481-9255

## Certified Clinical Supervisor Application

### I. Personal Data

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone (w) \_\_\_\_/\_\_\_\_/\_\_\_\_ (h) \_\_\_\_/\_\_\_\_/\_\_\_\_ (c) \_\_\_\_/\_\_\_\_/\_\_\_\_

FAX \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Are you an IAAP member: \_\_\_No \_\_\_Yes ID # \_\_\_\_\_ Expiration Date \_\_\_\_\_

### II. Licensure/Certification/Education Record

*Current License/Certification:* Please list each License/Certification/Degree you currently hold:

Credential #	Issuing Authority	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Note:** Copies of current Licenses/Certifications/Degrees *must* be attached.

**Important:** You *MUST* attach a copy of your IAAP Certificate(s) of Attendance for the minimum of 12 required clock hours of Clinical Supervision training, *or your application can not be processed.*

### III. Career History

In providing your addiction counseling career history, please list your current position first and work backwards until you document a minimum of three (3) years experience (6,000 hours) as an Addiction Counselor with a minimum of two (2) years post grad. experience. Attach additional pages as needed.

Employer: \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ From (M/Y) \_\_\_\_\_ to (M/Y) \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Job Title: \_\_\_\_\_ Brief job description: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Telephone \_\_\_\_/\_\_\_\_

**IV. Application Checklist**

- \_\_\_ Application Form
- \_\_\_ License/Certification Copies
- \_\_\_ Education/Training Certificate Copies
- \_\_\_ Supervisor's Signature (Section IV)
- \_\_\_ Your Signature (Section X)
- \_\_\_ Payment ICAC I or II (IAAP Member \_\_\_ / Non-Member \_\_\_)

**V. Payment**

Amount Enclosed: \_\_\_\_\_ Check (payable to IAAP) \_\_\_\_\_ Money Order \_\_\_\_\_

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**FOR OFFICE USE ONLY**

\_\_\_ Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it complete and correct. Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ NOT Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it incomplete or incorrect, and needing the following information/correction(s) for approval:

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Decision Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

(Cert. Board Chair)