Certified Addiction Professional
Tier II On-the-Job Supervision Verification Form

DIRECTIONS

This form allows for one qualified supervisor to document clinical on-the-job supervision hours as required for the CAP credential. Provide a separate form and instructions to each qualified supervisor who will document supervision for certification purposes. FCB has supervision documentation templates posted online that may be used if needed.

All information must be TYPED. Handwritten forms will be denied. This is a two-part form.

- Part One is completed by the applicant and provided to the qualified supervisor.
- Part Two is completed by the qualified supervisor and provided to FCB by mail, email, or fax (see below).

Upon completion, please submit the form directly to the FCB. *On-the-Job Supervision Verification Forms* will not be accepted from the applicant.

Mail: Florida Certification Board
Attn: Certification Operations
1715 South Gadsden Street
Tallahassee FL 32301

Email: Certification Specialist's email or admin_assist@flcertificationboard.org
Fax: 850-222-6247
Subject Line: On-the-Job Supervision (applicant name)

REQUIREMENT

On-the-Job Supervision Requirements	**150 hours total.** • 75 hours must be individual supervision. • No more than 75 hours can be group supervision. Eligible on-the-job supervision occurred within the five years before applying for certification.
Policy Standard	• Eligible supervision focuses on improved client care and improved job performance. The purpose of supervision is to teach counselors how to promote client welfare and increase their skills and knowledge to effectively treat their client base. • For certification purposes, the FCB benchmarks reasonable and achievable supervision at the rate of 3 hours per week/156 hours per year. • No more than 50% of the required hours of supervision may be in a group setting.
Qualified Supervisor Definition	A qualified supervisor must be current and fall within one of the following designations: • A physician or physician's assistant licensed under Chapters 458 or 459, F.S. • A professional licensed under Chapters 490 or 491, F.S. • A Psychiatric Advanced Registered Nurse Practitioner licensed under Part 1 of Chapter 464, F.S. and meeting the Board of Nursing requirements for a Psychiatric ARNP designation. • A MCAP or CAP A copy of the qualifying credential or license for the qualified supervisor must be attached.

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PERFORMANCE DOMAIN CATEGORIES

Minimum specified hours for supervision (individual or group) must be completed in each performance domain listed below. The remaining hours may be allocated across any of the domains.

Domain	Minimum Required Hours	Sample Tasks for Observation and Feedback
Clinical Evaluation	25	Conducting intake, orientation, screening, and assessment(s) to determine appropriateness for placement and/or develop diagnostic impressions and treatment recommendations.
Treatment Planning	25	Developing and/or updating treatment plans, including mutually agreed upon needs, goals, measurable objectives, treatment methods and discharge criteria.
Counseling	35	Providing individual and/or group counseling to clients and family members and counseling-related services such as relapse prevention and recovery support.
Case Management and Referral	15	Ensuring that client needs that cannot be met in the current treatment setting are addressed with other community resources in a manner that ensures ongoing continuity of care.
Client, Family, & Community Education	15	Developing and delivering education and training on health and high-risk behaviors associated with substance abuse, the continuum of care, medication-assisted treatment, and other related topics.
Documentation	15	Documenting clinical treatment, writing reports, and maintaining client records.
Legal and Professional Responsibility	20	Performing all tasks in a manner that follows generally accepted legal, ethical, and professional standards

SUPERVISOR REQUIRED DOCUMENTATION

A qualified supervisor must maintain documentation of supervision, copies of which may be requested by Certification Staff at any time. Documentation must include the following minimum information:

a. Supervisee name, current position and credential

b. Date of supervision, start and end time of supervision, and number of supervision hours

c. Supervisor name and title

d. Methods of supervision (individual, group, observation, review clinical documentation)

e. Summary of supervision offered during session

f. Signature of both Supervisee and Supervisor

Documentation does not need to be submitted with this verification form; however, it must be made available if requested by FCB. FCB has supervision documentation templates posted online, if needed.

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All information must be typed. Handwritten forms will be denied.

Part 1: To be completed by the applicant prior to providing to the qualified supervisor for completion.

Applicant Information: Please list the position you held for which you are requesting documentation of on-the-job supervision by a qualified supervisor. Report employment dates in the following format: MM/DD/YYYY to MM/DD/YYYY. Use a separate form for each qualified supervisor documenting one-on-one on-the-job supervision.
Applicant Name:
Employer:
Type of Position: ❒ Full-Time ❒ Part Time
Average Hours Worked Per Week:
Position Title:

Part 2: To be completed by the applicant's qualified supervisor only.

Section A: Qualified Supervisor Contact Information	
Last Name:	**First Name:**
Title:	**Employer:**
Email Address:	**Business Phone:**
Work Address:	
City:	**State:**
Zip Code:	**County:**

Section B: Supervision Attestation

I am a qualified supervisor because I am:

- ❒ A physician or physician's assistant licensed under Chapters 458 or 459, F.S.
- ❒ A professional licensed under Chapters 490 or 491, F.S.
- ❒ A Psychiatric Advanced Registered Nurse Practitioner licensed under Part 1 of Chapter 464, F.S. and meeting the Board of Nursing requirements for a Psychiatric ARNP designation.
- ❒ A MCAP or CAP credentialed through the Florida Certification Board.

A copy of my qualifying credential or license is attached. ❒ *Yes* ❒ *No*

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Section B: Supervision Attestation Continued		
Domain	**Individual Supervision Hours**	**Group Supervision Hours**
Clinical Evaluation (25 Hours)		
Treatment Planning (25 Hours)		
Counseling (35 Hours)		
Case Management and Referral (15 Hours)		
Documentation (15 Hours)		
Client, Family and Community Education (15 Hours)		
Ethical And Professional Responsibilities (20 Hours)		
TOTAL HOURS PER CATEGORY:		
TOTAL HOURS OF ON-THE-JOB SUPERVISION:		

Type of Position Supervised ❒ Full-Time ❒ Part Time

Supervision Timeframe: From: _____ To: _____

Do you have any concerns about the applicant's ability to competently perform as a Certified Addiction Professional?

❒ Yes* ❒ No

**If yes, please attach an additional page describing your concerns. The FCB may contact you for further discussion.*

By my signature, I attest that I provided on-the-job supervision to _____ as they performed addiction related services at the level expected of a Certified Addiction Professional (CAP), and

I maintain documentation to support the supervision hours reported on this form, and

The information I provided is true, and

I consent to an interview regarding this document if requested by the Board.

Qualified Supervisor's Signature *(FCB accepts manual and electronic signatures)* **Date**