

**THE MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR
CERTIFICATION, INC.**

SUPERVISOR VERIFICATION FORM
for the
PREVENTION SPECIALIST

CONFIDENTIAL

TO BE COMPLETED BY APPLICANT

APPLICANT NAME: _____ DATE: _____
(PLEASE PRINT)

I authorize the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) to seek additional information about my work in prevention from the supervisor listed below.

PRINT NAME OF SUPERVISOR

APPLICANT'S SIGNATURE

I hereby waive my right to inspect this verification form and any subsequent information provided by the supervisor in connection with my application for Certification.

APPLICANT'S SIGNATURE

Dear Supervisor:

The individual named above is applying to MBSACC for Certification as a Certified Prevention Specialist (CPS). You have been identified by the applicant as a supervisor for part or all of his/her prevention work experience; therefore, the information requested from you is an essential part of the Board's evaluation of the eligibility of this applicant. This completed form must be on file before the application can be reviewed and processed. Please confirm with the applicant the date by which this completed verification form must be postmarked by you in order to meet the application deadline date requirement.

*The Board appreciates your accurate and truthful reporting. This form will be considered by the Board to be **confidential** and will not be made available to the applicant. As Supervisor, you may wish to keep a photocopy of this Verification Form for your files, but you must **not** supply a copy of the completed form to the applicant. The applicant has waived his/her right to view the contents of this form. MBSACC reserves the right to request further information from you, if necessary, concerning this applicant.*

MBSACC

Please return the completed form directly to us at: MBSACC, 560 Lincoln St.,
P.O. Box 7070, Worcester, MA 01605. We thank you for your cooperation.

PART A

SUPERVISOR'S NAME

SUPERVISOR'S CURRENT JOB TITLE

CURRENT AGENCY NAME & ADDRESS

(_____) _____
AGENCY PHONE NUMBER (Please include area code)

HIGHEST DEGREE EARNED

PLEASE LIST ANY CERTIFICATIONS OR LICENSES YOU CURRENTLY HOLD AND THE STATE(S) FROM WHICH THEY WERE ISSUED; IF THE CERTIFICATION OR LICENSE IS NATIONAL, PLEASE SO NOTE:

WHERE DID YOU RECEIVE YOUR PREVENTION TRAINING (i.e., name of agency, name of institute. etc.)?

RELATIONSHIP TO APPLICANT: (PLEASE CHECK ONE)

- CONSULTANT PRESENT SUPERVISOR PAST SUPERVISOR OTHER (Specify) _____

PART B

(Part B is for verifying the applicant's prevention employment.)

NAME OF AGENCY WHERE SUPERVISION OCCURRED

AGENCY ADDRESS

SUPERVISOR'S JOB TITLE AT TIME OF SUPERVISION

APPLICANT'S JOB TITLE AT TIME OF SUPERVISION

HOW LONG HAVE YOU BEEN EMPLOYED BY THIS AGENCY? _____

WERE YOU INVOLVED IN THE ADMINISTRATION/MANAGEMENT OF THE PROGRAM WHERE SUPERVISION TOOK PLACE?

- YES, BUT LIMITED TO SUPERVISORY ASPECTS (i.e., supervision of prevention staff)
 YES, BUT LIMITED TO ADMINISTRATIVE RESPONSIBILITIES (i.e., budgeting, etc.)
 YES – BOTH SUPERVISORY AND ADMINISTRATIVELY
 NO _____
(PLEASE SPECIFY)

APPLICANT'S DATES OF EMPLOYMENT PROVIDING PREVENTION SERVICES WITH THIS AGENCY:

From: _____/_____/_____
 Month Day Year

To: _____/_____/_____
 Month Day Year

PART B (Cont'd.)

FOR WHAT PERIOD OF TIME DID YOU PROVIDE PREVENTION SUPERVISION FOR THIS APPLICANT?

From: _____ / _____ / _____ To: _____ / _____ / _____
Month Day Year Month Day Year

NUMBER OF HOURS OF DIRECT (FACE-TO-FACE) SUPERVISION PER WEEK FOR PERIOD LISTED ABOVE: _____

NUMBER OF HOURS APPLICANT WORKED PER WEEK: _____

TOTAL NUMBER OF HOURS PER WEEK APPLICANT SPENT IN PREVENTION ACTIVITIES: _____

IN THE SPACE BELOW, PLEASE PROVIDE A DETAILED DESCRIPTION OF THE APPLICANT'S PRIMARY JOB RESPONSIBILITIES AT THE TIME OF SUPERVISION.

*I hereby attest that **either** a minimum of 51% of the applicant's time is spent providing alcohol, tobacco, and/or other drug abuse prevention activities/services **or** a minimum of 51% of the applicant's time is spent providing **supervision** of prevention activities/services.*

SUPERVISOR'S SIGNATURE

PART C

DESCRIBE THE PROCEDURE USED IN SUPERVISION WITH THE APPLICANT. YOUR COMMENTS IN THIS PORTION ARE CONSIDERED *VERY IMPORTANT*. PLEASE COMPLETE IT CAREFULLY.

PART D

PLEASE READ THE STATEMENTS BELOW WHICH DESCRIBE VARIOUS SKILLS NEEDED BY THE PREVENTION SPECIALIST. USING THE FOLLOWING SCALE, RATE THE APPLICANT'S ABILITY, AND PLACE THE APPROPRIATE NUMBER VALUE ON THE BLANK LINE TO THE LEFT OF EACH STATEMENT.

SCORING SCALE:

1 = NOT APPLICABLE

2 = DON'T KNOW

3 = POOR

4 = AVERAGE

5 = ABOVE AVERAGE

6 = SUPERIOR

- _____ IDENTIFIES FINANCIAL SOURCES AND STRATEGIES
- _____ FACILITATES COMMUNITY AWARENESS
- _____ DOCUMENTS PROJECT ACTIVITIES AND OUTCOMES
- _____ ASSESSES TRAINING NEEDS
- _____ ADDRESSES EDUCATIONAL NEEDS OF AUDIENCE
- _____ PROVIDES RELEVANT INFORMATION
- _____ SELECTS **ATOD** PREVENTION MATERIALS AND RESOURCES
- _____ CONDUCTS TRAINING EVALUATIONS
- _____ PROVIDES PREVENTION INFORMATION TO PROFESSIONALS IN RELATED FIELDS
- _____ ASSISTS CONSUMERS IN IDENTIFYING SPECIFIC ISSUES
- _____ ESTABLISHES A COMMUNITY NETWORK
- _____ CONSTRUCTS A COMPREHENSIVE PREVENTION PLAN WITH COMMUNITY MEMBERS
- _____ INCREASES COMMUNITY INVOLVEMENT
- _____ FACILITATES DEVELOPMENT OF LOCAL LEADERSHIP
- _____ INFORMS POLICY MAKERS OF PREVENTION PROGRAM EFFECTIVENESS
- _____ ATTAINS KNOWLEDGE OF CURRENT RESEARCH-BASED PREVENTION TRENDS
- _____ ASSESSES COMMUNITY NEEDS THROUGH SYSTEMATIC DATA COLLECTION METHODS
- _____ CONDUCTS AN EVALUATION OF PREVENTION PROGRAM THROUGH ASSESSMENT METHODS
- _____ COORDINATES DEVELOPMENT OF APPROPRIATE PREVENTION PLAN WITH CONSUMER PARTICIPATION
- _____ PRACTICES ETHICAL BEHAVIOR TO PROMOTE INTEGRITY OF THE PROFESSION

PART E

PLEASE DESCRIBE ANY SPECIAL SKILLS OF THE APPLICANT –

COMMENTS AND/OR ADDITIONAL INFORMATION YOU FEEL MAY BE PERTINENT –

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

Please specify _____

- I DO NOT RECOMMEND THIS APPLICANT FOR CERTIFICATION

Please specify _____

THE SUPERVISOR COMPLETING THIS VERIFICATION FORM MUST READ THE FOLLOWING STATEMENT AND SIGN BELOW:

I ATTEST THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED IN THIS VERIFICATION FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SUPERVISOR'S NAME (*Please print here*)

SUPERVISOR'S TITLE (*Please print here*)

SUPERVISOR'S SIGNATURE

DATE

CPS PERFORMANCE DOMAIN SUPERVISION DOCUMENTATION

APPLICANT'S NAME: _____

NOTE: An applicant for certification as a Prevention Specialist must show that s/he has had supervision in five prevention domains. These domains (and a brief description of each) are listed in the table below. A minimum of 10 hours of supervision is required in each domain; however, the total accumulated hours must be equal to or greater than 120 hours of supervision.

TO SUPERVISOR: Please complete this form indicating the applicant's on-the-job supervision in the prevention domains. (This should **not** reflect the number of hours the applicant has worked, but rather this should reflect the number of on-the-job hours of supervision you have provided to the applicant in each domain.)

PERFORMANCE DOMAINS	# HOURS
Domain 1: Planning and Evaluation – Assessing community needs, developing a prevention plan, securing funding, and documenting outcomes.	
Domain 2: Education and Skill Development – Developing and delivering culturally competent education and training to communities, groups, and other professionals.	
Domain 3: Community Organization – Identifying and engaging community leaders, providing technical assistance to those leaders, and assisting them in sustaining positive change.	
Domain 4: Public Policy and Environmental Change – Identifying policy makers, assisting community leaders in gaining support for environmental change in communities, and creating a positive environment in the community.	
Domain 5: Professional Growth and Responsibility – Practice ethical behavior, model collaboration with colleagues and community organizations, and continue growth in cultural competence and prevention knowledge.	

TOTAL # OF HOURS _____

AGENCY WHERE SUPERVISION TOOK PLACE: _____

I attest that the above reported information is, to the best of my knowledge, an accurate accounting of the supervision I have provided to this applicant.

SUPERVISOR'S NAME (PLEASE PRINT HERE)

DATE

SUPERVISOR'S SIGNATURE