AFFIDAVIT OF FULFILLMENT OF 3000 HOURS OF AOD COUNSELING FIELD EXPERIENCE

I, _____, declare that I am the
(Supervisor's Name)

_____
(Supervisor's Title)

of _____ _____
(Treatment Facility Name) (Facility license/certification #)

_____
(Supervisor's degree and/or certification designation)

I attest that _____
(name of applicant)

has worked in our organization no less than _____hours as a
(Hours)

_____ between the dates of
(Job Title)

_____ and _____.
(month) (year) (month) (year)

My Professional Qualifications are as follows:

_____
_____
_____
_____
_____
_____

The supervisor signing this document must be a state licensed or certified AOD counselor with a level of certification greater than the one the applicant is seeking to obtain, be in a AOD clinical supervisor position, or be a licensed health care professional in a AOD clinical supervisor position.

_____ _____
Supervisor's signature License / Certification #

_____
Date