AR Department of Health
State Board of Examiners of Alcoholism & Drug Abuse Counselors
4815 West Markham, Box 42A
Little Rock, AR 72205
Phone: (501) 295-1100 Fax: (501)251-1151
E-mail: sbeadac@gmail.com

VERIFICATION OF SUPERVISION

I _____, hereby attest that I have completed a minimum of three (3) years of supervised experience providing counseling services to persons with addiction problems.

I understand that a Supervisor, approved by the Board of Examiners of Alcoholism and Drug Abuse Counselors, will verify my supervised experience based on the documentation presented to the SBEADAC.

_____	_____
Signature of Applicant	**Signature – SBEADAC Board Member**
_____	_____
Date	**Date**

I, _____ _____
Name Credentials
have been the supervisor of:_____
from the time frame of:_____.
Her/his duties consisted of:_____
_____
_____
_____
_____
_____
_____
_____
_____
Signed:_____ **Date:**_____