OKLAHOMA BOARD OF LICENSED ALCOHOL AND DRUG COUNSELORS

P O Box 54388
Oklahoma City, OK 73154-0388

EMPLOYMENT VERIFICATION FORM

APPLICANT NAME:_____

DATE:_____

Dear Program Director/Administrator:

The above named individual is applying to: **OKLAHOMA BOARD OF LICENSED ALCOHOL & DRUG COUNSELORS** for Licensure/Certification as a Counselor. Licensure/Certification of Alcohol/Drug Counselors in the State of Oklahoma is a competency-based process. The information below has been submitted to the Licensure Board as his/her supervised work experience, **delivering direct counseling** services to Alcohol/Drug Abuse clients. Your verification of this work experience as well as any additional comments you feel might aid in an accurate assessment of this applicant's ability as an Alcohol/Drug Counselor will play a significant part in the total evaluation process. The process can only be as good as you and others make it by careful and truthful reporting.

The applicant has filled out part A of this verification form. Part B and C should be completed by the Program Director/Administrator
.

PART A – The Applicant reports the following:

(Check one) Counselor____ Intern or Trainee ____ Volunteer____	**Period Worked:** Month & Year From_____ (mm/dd/yyyy) To_____ (mm/dd/yyyy) Total Years_____ Months_____ Average Weekly Work Hours_____ (No more than 60/wk)	**Name & Address of Employer/Agency** **Phone Number( )**	**Applicant Title:** **Name of Clinical Supervisor:** **Name of Administrative Supervisor**
Total Number of Hours per week in Direct Client Counseling _____	**Type of Counseling** (Hrs. per week) ____Hrs. of individual Counseling ____Hrs. of group Counseling ____Hrs. of family & signif. Others counseling	**Description of Caseload:** **_____% of clients with primary and secondary diagnosis of alcohol and drug abuse**	

PART A Continued

I AUTHORIZE THE OKLAHOMA BOARD OF LICENSED ALCOHOL AND DRUG COUNSELORS TO SEEK ADDITIONAL INFORMATION ABOUT MY WORK AND COUNSELING SKILLS FROM THE INDIVIDUAL SIGNING THIS VERIFICATION FORM

_____
Signature of applicant **Date**

PART B – Additional information and or corrections (to be filled out by Program Director/Administrator)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PART C

I have read the above information and provided additional information, where necessary, and verify it to be accurate to the best of my knowledge.

_____	_____	_____	_____
Director/Administrator	Title	Program	Date

RETURN THIS FORM TO: OBLADC
P O Box 54388
Oklahoma City, OK 73154-0388