



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Professional Licensing Administration
899 North Capitol Street, NE – First Floor
Washington, DC 20002
BOARD OF PROFESSIONAL COUNSELING

CERTIFIED ADDICTION COUNSELING APPLICANT:

This form must be returned in a sealed envelope and hand delivered to the office of Health Professional Licensing Administration by the applicant. Please note: You must have a Certification application on file.

TEMPORARY ADDICTION COUNSELING PRACTICE FORM TO BE COMPLETED BY
THE ADDICTION COUNSELORS SUPERVISOR OF RECORD

TO THE SUPERVISOR:

This form must be completed if you are supervising an applicant for licensure as a Certified Addiction Counselor. In accordance with Title 17 of the District of Columbia Municipal Regulations, section 8715.8 “a supervisor shall take full responsibility for all services provided by an addiction counselor under the supervisor’s supervision.” The Board advises all supervisors to read the District of Columbia Municipal Regulations sections 8714 and 8715 thoroughly prior to signing off on this document.

An eligible applicant may work under supervised practice from the date of signature on this form by an authorized representative for the Board of Professional Counseling for a maximum of one (1) calendar year This supervised practice form shall be issued only one time. Please note you must have completed all supervision and/or National Examination by the end date of the Temporary Practice Form.

Supervisor’s name and license number (Please Print):

 LAST NAME FIRST NAME MI LICENSE NUMBER
 Contact Phone Number: _(____)_____

Applicant’s name (Please Print):

 LAST NAME FIRST NAME MI

Location of Practice (Facility Name): _____

Brief description of applicant’s duties and responsibilities:

| SUPERVISOR’S SIGNATURE | PHONE NUMBER | DATE |
|------------------------|--------------|------|
| | | |

FOR OFFICE USE ONLY

Date Supervision Form submitted: _____ **Date supervision will end:** _____

Date of Board Review: _____

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HPLA Staff Signature: _____