

**AFFIDAVIT OF FULFILLMENT OF 255 HOURS
OF FIELD PRACTICUM IN AOD COUNSELING SERVICES**

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