

**AFFIDAVIT OF FULFILLMENT OF 160 HOURS OF SUPERVISED  
TRAINING AND WORK EXPERIENCE IN COUNSELING SERVICES**

I, \_\_\_\_\_, declare that I am the  
(Supervisor's name)

\_\_\_\_\_  
(Title)

of \_\_\_\_\_.  
(AOD Organization)

\_\_\_\_\_  
(Supervisor's license and/or certification designation)

I attest that \_\_\_\_\_  
(Name of applicant)

has worked under my direct supervision no less than \_\_\_\_\_ hours as

\_\_\_\_\_ between the dates of

\_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_, \_\_\_\_\_.  
(month) (year) (month) (year)

My Professional Qualifications are (continue on other side of this page if needed):

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Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_