WORK EXPERIENCE VERIFICATION RECORD FORM

LAST NAME: _____ FIRST NAME: _____ SSN #: XXX-XX-_____

Consent to Release Information -- By my signature below, I am authorizing the provider/person identified below to provide information and documentation to OASAS. I attest that the work experience hours claimed were **NOT** gained during the course of, or as part of, my participation as a service recipient in a formal SUD treatment/aftercare program and/or plan.

By my signature below, I am attesting that the information provided is true and correct to the best of my knowledge. All statements made in connection with this application are subject to investigation and verification. Falsification or omission of information in this attestation may result in administrative action against me by OASAS, including denial of my application and/or revocation of any OASAS issued credential that I hold. I understand that knowingly making a false statement on this application or any attachment or supporting document is punishable as a misdemeanor pursuant to Section 210.45 of the NYS Penal Law.

_____ _____

Applicant Signature **Date**

NOTE TO APPLICANT: Do not fill out any part of the form from this point on yourself or the form may be denied.

THIS PAGE TO BE COMPLETED BY HUMAN RESOURCES REPRESENTATIVE OR AUTHORIZED REPRESENTATIVE ONLY

If non-paid or internship this part can be completed by the QHP Supervisor

SUPERVISOR NAME/TITLE: _____

PROVIDER/EMPLOYER NAME: _____

UNIT WHERE APPLICANT WORKED: _____

OASAS OPERATING CERTIFICATE #: _____ **WORK SITE TELEPHONE NUMBER: (____)**_____

WORK ADDRESS (Must match OASAS Certificate as listed above):

_____ _____ _____ _____

Street **City/Town/Village** **State** **Zip Code**

(1) It is operated by OASAS (i.e., Addiction Treatment Centers) and/or it holds a valid OASAS operating certificate to provide treatment services or a similar license or approval from another state. ☐

(2) It is a program that includes SUD treatment consistent with OASAS' standards and is licensed and/or operated by another recognized State or Federal government authority to include the Indian Health Service and Veterans Administration. ☐

(3) It is a non-certified setting which involves: (1) the legal provision of addiction services; (2) the opportunity to establish proficiency in one or more of the professional competencies associated with a credential administered by OASAS; and (3) on-site supervision by a QHP meeting the supervisory standards established by OASAS. Only 50 percent of the required work experience may be obtained in this work setting. ☐

*** NOTE: If you've chosen work setting #3, you are not authorized to provide Individual/Group Counseling (SUD) and/or Treatment Planning. Provision of such services may require OASAS certification.**

Applicant's Job Title: _____ **Dates of Employment:** _____ **to** _____

month/day/year **month/day/year**

Total # Clock Hours Actually Worked (excluding holidays, Vacation, sick leave, etc.): _____

Note: Work experience post 7/1/18 must be in compliance with the SUD Counselor Scope of Practice. Two separate forms may be required.

AUTHORIZED HUMAN RESOURCES/PAYROLL REPRESENTATIVE CERTIFICATION I have reviewed employment records and certify that the information provided on the work experience hours of the above-named applicant is true to the best of my knowledge and belief. I attest that the work experience hours claimed were not gained during the course of, or as part of, the applicant's participation as a service recipient in a formal SUD treatment/aftercare program and/or plan.

Name of Authorized Representative (Please Print): _____ **Job Title:** _____

_____ _____ ( )

Signature of Authorized Rep. **Date** **Work Site Telephone Number**

WORK EXPERIENCE VERIFICATION RECORD FORM (continued)

APPLICANT NAME:_____ **PROGRAM NAME:**_____

Supervised Practical Training must be specific to SUD counseling for Work Settings #2 and #3.

Must include weekly, onsite, and documented clinical supervision by a QHP meeting the supervisory standards established by OASAS.

Each of the 12 Core Functions must have been performed for a minimum of 10 hours and a total of 300 hours under the supervision of a QHP meeting the supervisory standards established by OASAS. These minimum hours may be obtained from one or more supervisor(s)/provider(s)/ employer(s).

In each of the following 12 Core Functions (areas of professional expertise), the supervisor provided supervised practical training to the applicant as part of his/her work experience.

The supervisor has reviewed the records and certifies that the information provided on the supervised practical training of the above-named applicant is true to the best of their knowledge and belief.

*** In accordance with Mental Hygiene Law 32.05, it is important to note that, if you are providing Individual/Group Counseling (SUD) and/or Treatment Planning, your program may require certification by OASAS.**

SUPERVISED PRACTICALTRAINING:	# HOURS:
• Screening	
• Intake	
• Referral	
• Orientation	
• Treatment Planning *	
• Case Management	
• Crisis Intervention	
• Counseling *	
• Service recipient Education	
• Assessment and Intervention	
• Reporting and Record Keeping	
• Consultation with Other Professionals	
TOTAL # HOURS:	

APPLICANT JOB RESPONSIBILITIES:

During the dates of employment indicated below, the applicant was responsible for **substance use disorder (SUD)** related practice in the following areas (check all that apply):

PLEASE NOTE AN APPLICANT MUST PERFORM ALL FIVE JOB RESPONSIBLITIES FROM ONE OR MORE EMPLOYER(S) TO SATISFY THE REQUIREMENT.

- ☐ SUD Assessment
- ☐ Intervention
- ☐ Referral
- ☐ SUD Counseling (Individual) *
- ☐ SUD Counseling (Group) *

** In accordance with Mental Hygiene Law 32.05, it is important to note that, if you are providing Individual/Group Counseling (SUD), your program may require certification by OASAS.*

QUALIFIED HEALTH PROFESSIONAL CERTIFICATION: Check all **current** credentials or licenses that verify your status as a QHP. **(attach a copy of license)**

- ☐ CASAC Advanced Counselor #_____
- ☐ CASAC Master Counselor #_____
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Master Social Worker, including Limited Permit (LP-LMSW)
- ☐ Certified by the National Board for Certified Counselors
- ☐ Licensed Mental Health Counselor, including Limited Permit (LP-LMHC)
- ☐ Physician
- ☐ Physician's Assistant
- ☐ Registered Professional Nurse
- ☐ Licensed Nurse Practitioner
- ☐ Licensed Psychologist
- ☐ Other: _____
- ☐ Licensed Psychoanalyst
- ☐ Therapeutic Recreation Specialist
- ☐ Registered Occupational Therapist
- ☐ Certified Rehabilitation Counselor
- ☐ Licensed Creative Arts Therapist
- ☐ Licensed Marriage and Family Therapy

I attest that, as a QHP meeting the supervisory standards established by OASAS, I have had at least one year of experience in the treatment of SUD or I have completed a formal training program in the treatment of SUD, and that the supervised training hours claimed above were not gained during the course of, or as part of, the applicant's participation as a service recipient in a formal SUD treatment/aftercare program and/or plan.

By my signature below, I am attesting that the information provided is true and correct to the best of my knowledge. All statements made in connection with this application are subject to investigation and verification. Falsification or omission of information in this attestation may result in administrative action against me by OASAS I understand that knowingly making a false statement on this application or any attachment or supporting document is punishable as a misdemeanor pursuant to Section 210.45 of the NYS Penal Law.

Name of Applicant's Supervisor (Please Print): _____ **Job Title:** _____

_____ **Signature of Applicant's Supervisor**

_____ **Date**

( ) _____ **Work Site Telephone Number**