

**Addictive Disorders Regulatory Authority
(ADRA)**

Application for Certified Clinical Supervisor (CCS)

NAME: _____ **Date:** _____

Address: _____

City, State: _____ **Zip:** _____

Home Phone: (_____) _____ - _____ **E-mail Address:** _____

Soc. Sec. #: _____ - _____ - _____ **Date of Birth:** _____

EMPLOYER: _____

Position: _____

Address: _____

City, State: _____ **Zip:** _____

Work Phone: (_____) _____ - _____

Supervisor: _____

Preferred Mailing Address: _____ Home _____ Work

I hereby certify that I am qualified to hold the designation of Certified Counselor Supervisor. I understand that this privilege entitles me to supervise individuals registered as Counselor in Training, to review institutions which are registered as training and/or education providers, and to validate and evaluate the experience of applicants. I pledge to abide by the Rules and Regulations of the ADRA. I understand that I am responsible for biennial renewal of my registration. (48 hours of CEU's, 6 in ethics and 8 specific to supervision) I submit the following documentation:

1. Copy of current valid LAC, CAC, RAC or other appropriate license (approved by the ADRA).
2. Copy of certificate demonstrating that I have passed the exam approved by the ADRA.

I agree to keep the above information current and notify the ADRA of any changes, and I understand that failure to do so is an ethical violation.

Signature: _____ **Date:** _____

Cashiers Check or Money Order for \$100.00 application fee made payable to: ADRA

**Mail This Form and Payment to:
ADRA – Registration
628 North Fourth Street
Baton Rouge, LA 70802**

For Office Use Only

Received: _____ **Check #:** _____ **Reviewed:** _____ **CCS #:** _____ **Mailed:** _____