

**Addictive Disorders Regulatory Authority
(ADRA)**

Supervisor change for Counselor/Prevention Specialist in Training

NAME: _____ **Date:** _____

Address: _____

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

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

Soc. Sec #: _____ - _____ - _____ **Date of Birth:** _____ **Age:** _____
(Must be at least 18 year old)

EMPLOYER: _____

Position: _____

Address: _____

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

Work Phone: (_____) _____ - _____

Former Supervisor: _____

New Supervisor: _____

New Supervisor's Mailing Address: _____

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

Effective Date of change in supervision: _____

CIT/PSIT Signature : _____ **Date:** _____

New supervisor's statement:

I have agreed to serve as the qualified professional supervisor for the above individual while in training. I will notify the ADRA immediately if this agreement ceases.

Supervisor's Signature: _____ **Date:** _____

___ I am certified with the ADRA as a Certified Counselor Supervisor: CCS # _____.

___ I am certified with the ADRA as a Licensed, Certified or Registered Prevention Professional: # _____.

___ I am not registered, but have obtained a valid waiver. (Attach copy)

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