Co-Occurring Disorder Specialist
Enhancement
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Co-Occurring Disorder Specialist Enhancement Supervised Experience

Applicant:

Use a separate form for each supervisor verifying your co-occurring disorder specialist supervised experience.

1. Print Clearly:

Name Last	First	Middle	Birth Date (mm/dd/yyyy)
Address			
City	State		Zip Code

2. Approved Supervisor: Please review RCW 18.205.105(5) (c)(i) or (c)(ii), WAC 246-809-090, and WAC 246-804.
An applicant for the co-occurring disorder specialist enhancement may receive supervised experience from any person who meets or exceeds the requirements of a certified substance use disorder professional in the state of Washington and who would be eligible to take the examination required for substance use disorder professional certification per RCW 18.205.105 (6).
The above individual seeks verification of co-occurring disorder specialist supervised experience for licensure as a co-occurring disorder specialist enhancement. Please complete the following:

Supervisor Name		Current Phone
Credential Number		First Issuance Date
Current Street Address		
City	State	Zip Code

3. Supervised Co-Occurring Disorder Specialist Experience:
Applicants must have eighty hours of supervised experience for an applicant listed in RCW 18.205.105(1) with fewer than five years of experience; or forty hours of experience for an applicant listed in RCW 18.205.105(1) with five or more years of experience. Please provide the actual hours in the space provided below.

	Hours Required	**Total Hours Verified**
Eighty hours of supervised experience for an applicant listed In RCW 18.205.105 (1) of this section with fewer than five years of experience	**80**	
Forty hours of supervised experience for an applicant listed in RCW 18.205.105 (1) of this section with five or more years of experience	**40**	

Supervisor

I certify that the above information is, to the best of my knowledge accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed the requirements of a certified substance use disorder professional in the state of Washington and who would be eligible to take the examination required for substance use disorder certification per RCW 18.205.105(6).

Signature of Supervisor: ____________________________ Date: ________________________________