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

Date Stamp Here

Agency Affiliated Counselor Co-Occurring Disorder Enhancement Verification of Prior Experience

Applicant:

Use this form to verify your experience prior to obtaining a co-occurring disorder specialist enhancement. Complete section one and forward to your approved supervisor or behavioral health agency to complete sections two or three. This form can be duplicated.

An agency affiliated counselor under chapter 18.19 RCW with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience, experience gained under the supervision of a mental health professional recognized by the department or attested to by the licensed behavioral health agency, in direct treatment of persons with mental illness or emotional disturbance.

I have two years of supervised experience in direct treatment of persons with mental illness or emotional disturbance under a:

☐ Mental Health Professional recognize by the department **-or-**

☐ Licensed Behavioral Health Agency

1. Applicant's Information

Name: First	Middle	Last
DOH Credential Number (if applicable)	Birth date (mm/dd/yyyy)	Email Address

2. Mental Health Professional Attestation

Supervisor's Name: First	Middle	Last
Date of Birth (mm/dd/yyyy)	Credential Number	
Applicant's Date of Experience	From (mm/dd/yyyy)	To (mm/dd/yyyy)

I certify, to the best of my knowledge that the above named applicant has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance. I understand that the Department may request additional information if it is needed to evaluate the application of the individual named on this document.

Signature:_____ Today's Date: _____

3. Behavioral Health Agency Attestation

Agency's Name	Agency's Credential Number

Agency's Mailing Address

City	State	Zip Code

Applicant's Date of Experience	From (mm/dd/yyyy)	To (mm/dd/yyyy)

I certify that I am an agency representative and have verified, to the best of my knowledge that the above named applicant has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance. I understand that the Department may request additional information if it is needed to evaluate the application of the individual named on this document.

Signature of Agency Representative:_____ Today's Date: _____

Print Name: _____