Review Checklist Clinical Supervision Distance

This page will be the first page of your packet. Please attach the documentation IN THE ORDER LISTED BELOW. It is the responsibility of the applicant to submit complete documentation (i.e. certificates, transcripts). Incomplete or disorganized packets will be returned to you. Testing Fees are nonrefundable. Please consult ASACB website for any questions.

Name of Applicant:_____ **Date:**

Mailing Address:_____**Daytime Phone:**

1. _____ Certified as CS: CS # _____

2. _____**Education**
   Completion of **6 hours** of Distance Clinical Supervision training approved by the ASACB Board

3. _____**Code of Ethics**
   The applicant must sign a statement that they understand and agree to comply with the ASACB Distance Clinical Supervision Code of Ethics.

4. _____**Fees ($50.00)**
   Fees must be received via the U.S. Postal System payable by personal check, traveler's check, cashier's check or money order.

_____ _____

SIGNATURE OF CLINICAL SUPERVISOR **DATE**

REVIEWED BY:

Approved_____Disapproved_____Education Committee Initials:_____Date_____

Approved_____Disapproved_____Education Committee Initials:_____Date_____

Payment Received_____-for ____Exam on _____ Date___ Receipt Number