CLINICAL SUPERVISOR STATEMENT (S.1)

*To be completed by **Clinical Supervisor***

CONFIDENTIAL EVALUATION
Please print or type all information

DO NOT RETURN THIS FORM TO THE APPLICANT

Applicant's Name: ____

I hereby certify that I have been in a position to observe and have first hand knowledge of the above named person's work at the

____
(Name of Company/Work Setting)

during the time period from ___________________________ to _______________________.

My relation to the person was ____.
(Supervisor)

During the above time period, I certify that I provided the applicant with a total of _________ hours of face to face supervisor relating to the applicant's work as a counselor.

The information I am giving is my best judgment of the above named person's capabilities to be certified as a California Gambling Counselor.

____
(Printed Name)

____
(Signature)

_____________________________ _________________________
(Title) (Date)

____
(Agency)

____
(Address of Agency)

____
(Day Phone)

Return this form (**S.1**) along with the **S.2** and **S.3** forms DIRECTLY to:

California Gambling Counselor Certification Board
41690 Ivy St., Suite A7 ◆ Murrieta, CA 92562
Phone (714) 765-5804 ◆ Fax (951) 266-0072