**FORM (S.1) – CLINICAL SUPERVISOR INFORMATION**

**CONFIDENTIAL**

*To be completed by clinical supervisor*

**DO NOT RETURN THIS FORM TO THE APPLICANT**

**Applicant's Name:** _____

Name and Title of Supervisor (please print): _____

Address: _____

Employer: _____

Position: _____

Email Address: _____Phone Number: _____

Highest academic degree/diploma: _____

Professional licensure/certification: _____

Please check the box(es) below that describe the workplace setting in which you supervise the applicant, and the population being served:

- ☐ Full time (applicant)
- ☐ Part time (applicant)
- ☐ Residential
- ☐ Out-patient
- ☐ Substance Use Disorder Treatment Program
- ☐ Program gambling treatment only
- ☐ Mental Health Agency
- ☐ Hospital
- ☐ Concurrent disorder program
- ☐ Prison Program
- ☐ Private Practice
- ☐ Disordered Gambling Integrated Program
- ☐ Youth
- ☐ Older Adults
- ☐ Other: _____

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

Return forms **S.1, S.2, S.3, and S.4** DIRECTLY to:

International Gambling Counselor Certification Board

***730 11th Street, NW Suite 601 ◆ Washington DC 20001***