FORM (S.2) – CLINICAL SUPERVISOR EVALUATION

CONFIDENTIAL

To be completed by clinical supervisor

DO NOT RETURN THIS FORM TO THE APPLICANT

Applicant's Name: ____

The information I am giving is my best judgment of the above named person's capabilities with respect to certification as a gambling counselor or co-occurring gambling specialist.

I hereby certify that I have been in a position to observe and have first-hand knowledge of the above named person's work during the period from ____________________ to ___________________.

(month/year) **(month/year)**

The applicant is applying for: IGDC ☐

The applicant has a total of: ☐ 50 counseling hours for International Gaming Disorder Certificate (IGDC)

Based on my knowledge of this applicant's eligibility and professional experience:

- ☐ To my knowledge, the applicant **does** meet the below requirements:
- ☐ To my knowledge, the applicant **does not** meet the below requirements at this time

Direct contact hours for IGDC include counseling activities provided for individuals with primary or secondary gambling disorder and/or their families/concerned others (may include ancillary activities such as clinical documentation, treatment team meetings, case management, etc.).
Direct contact hours for IGDC include counseling activities that address gambling problems and/or the impact of gambling on recovery among clients with primary substance use or mental health disorders.
For more details on definition of direct contact hours and other certification criteria see www.igccb.org.

Comments:

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Name and title of supervisor (please print): ____

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