COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION

# CATEGORY 3- GRADUATE IN RELATED FIELD: EMPLOYMENT AND/OR SUPERVISION VERIFICATION FORM

All completed pages in this form must be uploaded to your application.

## Applicant Information

| **NAME** | First | Middle Initial | Last | Former Name (if applicable) |
|---|---|---|---|---|
| | | | | |

Release Statement: I, , am applying for certification as a Certified Rehabilitation Counselor and am required to provide verification of my employment under the supervision of a CRC. Please complete this form and return to the above address. My application cannot be processed until this information is received.

_____

Signature of CRC Applicant Date (mm/dd/yyyy)

## Employer/Supervisor Instructions:

The individual named above is applying for the CRC exam. An applicant's eligibility can only be evaluated if this verification form is completed.

1. Please complete/review this form.
2. Sign and return the form to applicant.
3. Note that timely return of this document is necessary to meet processing deadlines for the CRC exam.

## Information Supplied by Employer/Supervisor

| | |
|---|---|
| Company Name: | |
| Address: | |

| | |
|---|---|
| Applicant's official job title: | |

| |
|---|
| Dates of applicant's employment:<br>From (mm/dd/yyyy) To (mm/dd/yyyy) |

| |
|---|
| Total number of hours worked per week:<br>(refer to CRC Certification Guide for requirements) |
| Average number of hours spent under my supervision:<br>(if applicable) |

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| | | |
|---|---|---|
| Did this individual provide direct rehabilitation counseling services to individuals with disabilities? | Yes | No |
| Dates of applicant's supervision:<br>(if applicable) | From (mm/dd/yyyy) | To (mm/dd/yyyy) |

Applicant Name: _ _____

## Indicate the client population served

| Population load | % of total case | Population load | % of total case |
|---|---|---|---|
| Sensory Disabilities | % | Psychiatric Disabilities | % |
| Developmental Disabilities | % | Learning Disabilities | % |
| Neurological Disorders | % | Substance Dependencies | % |
| Physical Disabilities | % | Other | % |
| **Total percentage for this section must equal and not exceed 100%.** | | | |

**Summarize this individual's primary responsibilities while under your supervision.**

**JOB ACTIVITIES** *(Please check ALL duties performed by this applicant in each of the following job activities. Also indicate percent of workweek spent on each activity.*

There are a total EIGHT activity areas:
Counseling is required for all applicants. *Must include the minimum 10% requirement.*

Further, that the applicant must have minimally provided services in THREE of the following SEVEN activities: Case Management, Client Assessment, Service Planning for Individuals with Disabilities, Rehabilitation Services Coordination, Job Analysis, Job Development/Placement, or Advocacy

*In addition, services must include ONE of the following **FOUR** activities: Case Management, Client Assessment, Service Planning for Individuals with Disabilities or Rehabilitation Services Coordination.*

*The combination of the time spent in these SEVEN activities must be no less than 40%.*

**The statements below represent rehabilitation counseling activities that might be performed by the applicant in delivering services. Please check the appropriate responses.**

| | Performed in position | **Not** performed in position | Percent of time spent on the activity |
|---|---|---|---|
| Counseling (minimum requirement 10%) | | | % |
| **Case Management** | | | % |

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| | |
|---|---|
| **Client Assessment** | % |
| **Service Planning for Individuals with Disabilities** | % |
| **Rehabilitation Services Coordination** | % |
| Job Analysis | % |
| Job Development/Placement | % |
| Advocacy | % |
| Total percentage for this section must be 50% (minimum 10% counseling, ≥ 40% in the other 7 areas), and not exceed 100%. | |

Applicant Name: _ _____

I hereby certify that the applicant named in this verification form received periodic evaluations of the quality of his/her delivery of rehabilitation counseling services while under my supervision/employment, and I further certify that the information I have provided is accurate. I understand that any discrepancies in the facts given here will prevent the applicant from sitting for the CRC exam.

| | |
|---|---|
| Signature | Title |
| Printed Name | Date (mm/dd/yyyy) |

| Relationship to applicant during this employment period: | | |
|---|---|---|
| Supervisor | Employer | Other (please specify) |

## Verification of Supervision by a CRC

Supervision is defined by CRCC as the systematic and periodic evaluation of the quality of the delivery of rehabilitation counseling services. By possessing the CRC credential, the supervisor has demonstrated that he/she has acquired and maintained specific competencies to practice as a rehabilitation counselor. A minimum of 12 months of supervision is necessary for certification. The supervision may be done by face-to-face meetings or via telephonic and/or electronic means of communication.

I was this applicant's supervisor and, during such time, I was a CRC. I hereby certify that the applicant named on this form received a systematic and periodic evaluation of the quality of his/her delivery of services as a rehabilitation counselor while under my supervision.

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| | |
|---|---|
| Supervisor's Signature | Date (mm/dd/yyyy) |

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Printed Name | Customer #

Applicant: Please return to My Account on the CRCC website to upload this completed form.