



COMMISSION ON REHABILITATION  
COUNSELOR CERTIFICATION

## CATEGORY 2– STUDENT ENROLLED IN A NON-CACREP ACCREDITED PROGRAM

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

### INTERNSHIP SUPERVISION VERIFICATION FORM

#### Supervisor Instructions:

The individual named below is applying for the CRC exam. An applicant's eligibility can only be evaluated if this verification form is completed. This form must be completed by the CRC faculty member or a CRC site supervisor who supervised the applicant named below in his/her rehabilitation counseling internship.

1. Please complete Section 2 of this form titled "Information Supplied by Supervisor."
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.

#### 1. Applicant Information

NAME	First	Middle Initial	Last	Former Name (if applicable)

ADDRESS				
Street Suite		Apartment/	City	State Zip Code

TELEPHONE				EMAIL ADDRESS (REQUIRED)
Preferred Phone Number	Area Code	Number	Extension	

Release Statement: I, \_\_\_\_\_, am applying for certification as a Certified Rehabilitation Counselor and am required to provide verification of my internship. My application cannot be processed until this information is received.

\_\_\_\_\_  
Signature of CRC Applicant

\_\_\_\_\_  
Date (mm/dd/yyyy)



---

COMMISSION ON REHABILITATION  
COUNSELOR CERTIFICATION



COMMISSION ON REHABILITATION  
COUNSELOR CERTIFICATION

Applicant Name: \_\_\_\_\_

## 2. Information Supplied by Supervisor

Indicate total number of clock hours completed at this site:					
Dates of internship:					
		From (mm/dd/yyyy)	To (mm/dd/yyyy)		
Internship site:					
City/State:					
Internship position title:					
Name of supervisor at the site:					
Name of faculty supervisor at the university:					
Total percentage of time during the internship period that the applicant spent delivering direct rehabilitation counseling services to individuals with disabilities: _____ %					
Indicate the client population served:					
	Population	% of total case load		Population	% of total case load
	Sensory Disabilities	%		Psychiatric Disabilities	%
	Developmental Disabilities	%		Learning Disabilities	%
	Neurological Disorders	%		Substance Dependencies	%
	Physical Disabilities	%		Other	%
<b>Total percentage for this section must equal and not exceed 100%.</b>					



**COMMISSION ON REHABILITATION  
COUNSELOR CERTIFICATION**

**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	<b>Not</b> performed in position	Percent of time spent on the activity
Counseling (must include a minimum 10%)			%
<b>Case Management</b>			%
<b>Client Assessment</b>			%
<b>Service Planning for Individuals with Disabilities</b>			%
<b>Rehabilitation Services Coordination</b>			%
Job Analysis			%
Job Development/Placement			%
Advocacy			%
Total percentage for this section must be 50% (minimum 10% Counseling, $\geq$ 40% in the other SEVEN areas), and not exceed 100%.			

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.



---

COMMISSION ON REHABILITATION  
COUNSELOR CERTIFICATION

---

Supervisor's Signature

Date (mm/dd/yyyy)

---

Printed Name

Customer #

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