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

First Name: ______________________ Middle Initial: ____ Last Name: ______________________

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): _______________

Information Supplied by Employer/Supervisor

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.

Company name: ____

Address: ____

Applicant's office job title: ____

Dates of applicant's employment: From: _______________ To: _____________________ (mm/dd/yyyy)

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COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION

Applicant Name: ____

Total number of hours worked per week (refer to CRC Certification Guide for requirements): _________

Average number of hours spent under my supervision (if applicable): _________

Did this individual provide direct rehabilitation counseling services to individuals with disabilities:

Yes No

Dates of applicant's supervision (if applicable): From: _________ To: ____________ (mm/dd/yyyy)

Indicate the client population served:

Check if served population	Population	% of total case load
☐	Sensory Disabilities	
☐	Developmental Disabilities	
☐	Neurological Disorders	
☐	Physical Disabilities	
☐	Psychiatric Disabilities	
☐	Learning Disabilities	
☐	Substance Dependencies	
☐	Other	

Total percentage for this section must equal and not exceed 100%:	

Summarize this individual's primary responsibilities while under your supervision:

COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION

Applicant Name:____

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. *

Counseling Activity	Check if performed in position	Check if NOT performed in position	Percent of time spent on the activity
Counseling (must include a minimum 10%)			
Case Management			
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 SEVEN areas), and not exceed 100%)

*The above percentage may be estimated if the student has not finalized the rehabilitation counseling internship.

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COMMISSION ON REHABILITATION COUNSELOR CERTIFICATION

Applicant name: ____

I hereby certify that the applicant named in this verification form received periodic evaluations of the quality of their 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, or specify if other):

☐ Supervisor

☐ Employer

☐ Other: ____

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 they have 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.

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.