



Washington State Department of
HEALTH
Co-Occurring Disorder Specialist
Enhancement
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Co-Occurring Disorder Specialist Enhancement Supervised Experience

Applicant:

Use a separate form for each supervisor verifying your co-occurring disorder specialist supervised experience.

1. Print Clearly:

| | | | |
|-----------|-------|----------|-------------------------|
| Name Last | First | Middle | Birth Date (mm/dd/yyyy) |
| Address | | | |
| City | State | Zip Code | |

- 2. Approved Supervisor:** Please review [RCW 18.205.105\(5\) \(c\)\(i\) or \(c\)\(ii\)](#), [WAC 246-809-090](#), and [WAC 246-804](#). An applicant for the co-occurring disorder specialist enhancement may receive supervised experience from any person who meets or exceeds the requirements of a certified substance use disorder professional in the state of Washington and who would be eligible to take the examination required for substance use disorder professional certification per [RCW 18.205.105 \(6\)](#).

The above individual seeks verification of co-occurring disorder specialist supervised experience for licensure as a co-occurring disorder specialist enhancement. Please complete the following:

| | |
|------------------------|---------------------|
| Supervisor Name | Current Phone |
| Credential Number | First Issuance Date |
| Current Street Address | |
| City | State |
| | Zip Code |

3. Supervised Co-Occurring Disorder Specialist Experience:

Applicants must have eighty hours of supervised experience for an applicant listed in [RCW 18.205.105\(1\)](#) with fewer than five years of experience; or forty hours of experience for an applicant listed in [RCW 18.205.105\(1\)](#) with five or more years of experience. Please provide the actual hours in the space provided below.

| | Hours Required | Total Hours Verified |
|--|----------------|----------------------|
| Eighty hours of supervised experience for an applicant listed in RCW 18.205.105 (1) of this section with fewer than five years of experience | 80 | |
| Forty hours of supervised experience for an applicant listed in RCW 18.205.105 (1) of this section with five or more years of experience | 40 | |

Supervisor

I certify that the above information is, to the best of my knowledge accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed the requirements of a certified substance use disorder professional in the state of Washington and who would be eligible to take the examination required for substance use disorder certification per [RCW 18.205.105\(6\)](#).

Signature of Supervisor: _____

Date: _____