**Treatment Supervision Fellowship Program Application**

1. **Program Overview**

Introduction

Thank you for applying to the Treatment Supervision Fellowship Program (Fellowship Program). The goal of this program is to prepare a new cohort of clinicians to provide clinical supervision for professionals who are eligible to treat gambling disorder.

In June 2016, each fellow will complete an evaluation process prior to graduation. To graduate, each Fellow will present 1) a case study utilizing an evidence based model of clinical supervision, and 2) a professional development plan outlining how they plan to utilize the skills and expertise gained through the fellowship program to the members of the Advisory Council.

Please complete this application in full and return to Colleen Fitzgibbons no later than **August 31** via e-mail at [cfitzgibbons@recres.org](mailto:cfitzgibbons@recres.org), fax to 216-431-4133, or mail it in to 3950 Chester Ave., Cleveland, OH 44114. Applications will not be accepted after August 31.

Program Requirements

* Gambling addiction treatment as a scope of practice.
* Ability to supervise under current license or working towards supervisor designation, including LISW-S, LPCC-S, LICDC-CS, MSW, LISW, LPCC, Ph.D, RN-BC, and MD.
* 3 years of experience in disordered gambling treatment.

Expectations of the Program

* Attendance at the *Gambling Disorder Supervision Training.*
* Attendance at monthly case consultation meetings. If more than one session is missed, a fellow is required to withdraw from the program.
* Attendance at the Ohio Problem Gambling Conference.
* Successful completion of an oral case presentation and professional development plan to the Treatment Supervision Fellowship Program Advisory Council.
* 12 hours of gambling-specific continuing education (of which 6 need to be in-person).

**Treatment Supervision Fellowship Program Calendar**

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| --- | --- | --- | --- |
|  | Date | Time | Location |
| *Gambling Disorder Supervision Training* | October 5, 2015 | 9:00 am – 4:30 pm | Columbus, OH |
| October Case Consultation | October 9th, 2015 | 12 pm – 2 pm | Conference Call |
| November Case Consultation | November 13th, 2015 | 12 pm – 4 pm | Zepf Center |
| December Case Consultation | December 11th, 2015 | 12 pm – 2 pm | Conference Call |
| January Case Consultation | January 8th, 2016 | 12 pm – 4 pm | Cleveland VA |
| February Case Consultation | February 12th, 2016 | 12 pm – 2 pm | Conference Call |
| March Case Consultation | March 2nd, 2016 | 12 pm – 4 pm | Columbus |
| Ohio Problem Gambling Conference | March 3rd & 4th 2016 | Two days | Columbus |
| April Case Consultation | April 8th, 2016 | 12 pm – 2 pm | Conference Call |
| May Case Consultation | May 13th, 2016 | 12 pm – 4 pm | CCAT House |
| Fellow Case Presentations | June 10th, 2016 | 8: 30 – 12:30 pm | Recovery Resources |
| Graduation lunch & professional development plan presentations | June 10th, 2016 | 12:30 pm – 4:00 pm | Recovery Resources |

Stipend

A stipend of up to $2,000 is available for fellows to assist with program-related costs. Prospective fellows are encouraged to work with their employer regarding travel costs associated with the program.

1. **Contact Information**

**Applicant Name** (first, middle and last):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maiden Name** (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social security number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **License** | **License Number** | **Expiration Date** |
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| --- | --- |
| **Current Home Address** | **Current Work Address** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Preferred Mailing Address**:

□ Home □Work

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Stipend**

Stipend amount requested (up to $2,000 available per fellow) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Resume**

Attach a copy of your most current resume.

1. **Gambling Scope of Practice**

To participate in the Treatment Supervision Fellowship Program, candidates must demonstrate a scope of practice in gambling disorder treatment. Gambling scope of practice can be demonstrated by either holding or working towards obtaining the Nationally Certified Gambling Counselors (NCGC) license through the International Gambling Counselor Certification Board (IGCCB) or the gambling endorsement through the Ohio Chemical Dependency Board (OCDB). For Social Workers treatment of clients with Gambling Disorder must be added to Scope of Practice with appropriate documentation of training/education hours. Please indicate the license you currently hold or are in the process of obtaining.

□ Nationally Certified Gambling Counselors

□ Gambling Endorsement

□ Added to Scope of Practice with appropriate training/education

Attach documentation verifying that you hold or are in the process of obtaining the above mentioned license or endorsement or Scope of Practice qualification.

1. **Supervision License**

Candidates for the Fellowship Program must be able to supervise under their current license or be in the process of obtaining their supervisor designation. This includes the following licenses: LISW-S, LPCC-S, LICDC-CS, MSW, LISW, LPCC, Ph.D, RN-BC, or MD.

**License** (circle): LISW-S LPCC-S LICDC-CS MSW LISW LPCC Ph.D RN-BC MD

**License Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Supervisor (if applicable)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Required Work Experience**

Applicants must complete three years of gambling disorder direct clinical experience. Verify completion of the required hours at the time of application by submitting a Gambling Disorder Experience Verification Form.

1. **References**

Two clinical references are required. Attach two letters of recommendation from clinicians that can speak to your experience in gambling disorder treatment.

1. **Confirmation of Program Dates**

I have received all program related dates, and am able to attend all required events.

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Signature of Applicant Date

1. **Essay**

In no more than 500 words, please describe how you will utilize the skills and knowledge gained through this program to advance the gambling disorder treatment field in Ohio. Please attach the essay as a separate document.

1. **Personal Information**

Have you ever had a professional license/certificate reprimanded, suspended, revoked, surrendered or in any other way sanctioned? If yes, please attach a written explanation.

□ Yes □ No

Have you ever been convicted of a felony? If yes, please complete the felony questionnaire.

□ Yes □ No

Do you currently live or work at least 51% of the time in Ohio?

□ Yes □ No

**Treatment Supervision Fellowship Program**

**Gambling Disorder Experience Verification Form**

This form is provided to document the required three years of gambling disorder direct clinical experience.

**INSTRUCTIONS TO APPLICANT:**

* Complete Part A and sign the Waiver of Liability before giving this form to your supervisor.

**PART A: TO BE COMPLETED BY THE APPLICANT**

1. Name of Applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

1. Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Employer name and address:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Job Title of Applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WAIVER OF LIABILITY**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applicant) (Supervisor)

to provide to the Board all information which the Board may deem relevant to my qualifications as an applicant for endorsement. I hereby release and discharge the supervisor from all claims arising out of the provision of such information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

**Treatment Supervision Fellowship Program**

**Supervisor Reference Form**

This form is provided to document the required three years of gambling disorder direct clinical experience.

**INSTRUCTIONS TO SUPERVISOR:**

* Review Part A of this form. Do not sign this form until you have reviewed Part A.
* Complete Part B ONLY if the waiver of liability has been signed by the applicant.

**PART B: TO BE COMPLETED BY SUPERVISOR**

1. Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Professional credentials and/or licenses you hold: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name of Applicant supervised: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Dates you have supervised this Applicant’s gambling disorder direct clinical experience:

From \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_

mo/yr mo/yr

Total hours of applicant’s gambling disorder

direct clinical experience at this setting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total number of hours of clinical

supervision with this applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you aware of any unethical professional behavior by this applicant?

□ Yes, please attach an explanation.

□ No

Do you recommend the applicant for the Fellowship Program?

□ Yes. Please provide a letter stating that the applicant will be provided support to attend

all mandatory training dates, case consultation calls and meetings needed to be

successful in this program.

□ No. Please attach an explanation.

I verify the above named individual has completed the above listed hours of gambling disorder direct clinical experience under my supervision.

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Signature of Supervisor Date