First Name:	Last Name:	MI:

CORE FUNCTION TRAINING

CORE FUNCTION TRAINING REQUIREMENT; 300 HOURS (see certification handbook)

Name of Supervisor/Trainer: ______________________________

Supervisor's Credentials:
____ADC II* Certification Number: ______________________
____ADC III* Certification Number: ______________________
____CCS I Certification Number: ______________________
____LADC License Number: ______________________
____CSW**
____Licensed Physician**
____Licensed Psychologist**
____Other/Specify ______________________

Supervisor's Title: ______________________________

Agency Name: ______________________ Agency Address: ______________________

______________________ : ______________________Zip: __________

Agency Phone # ______________________

Please indicate number of hours spent in each core function:

(see minimum hours required in each core function area in the certification handbook)

Core Function	Hours	Core Function	Hours
Screening (25)		Case Management (15)	
Intake (10)		Crisis Intervention (15)	
Orientation (10		Client Education (30)	
Assessment (40)		Referrals (10)	
Treatment Planning (20)		Reports and Record Keeping (30)	
Counseling (85)		Consultations (10)	
		Total:	

If you received core function training in more than one agency or from more than one trainer, please duplicate this form using one copy for each agency and/or trainer.