

ASSURANCE AND RELEASE

I _____, of _____ do hereby submit the following information, assurances and release relating to my initial certification or renewal of certification/licensure with the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)/Rhode Island Board for Licensing of Chemical Dependency Professionals (RIBLCDP)

I acknowledge and understand in answering the following questions that submitting fraudulent, deceitful or misleading statements will be grounds for denial or revocation of certification or renewal of certification.

Have you ever applied for certification/licensure as a chemical dependency professional in another state?
yes no

1) Have you ever had any action taken against your certification/license?
yes no

If the answer to Number Two (2) is Yes, please provide details on reverse side

3) Have you ever been disciplined in any way by a Certification/Licensing Board or Professional Organization?
yes no

If the answer to Number Three (3) is yes, please provide details on reverse side.

I hereby certify that I have read this entire application and that all the material contained herein is true, accurate and complete. I further understand that any intentionally false or misleading statements or omissions shall result in the denial or revocation of my certification/license or renewal of certification/license.

I hereby certify that all information contained in this application and any supporting documents is true to the best of my knowledge. I further certify that I do not use any controlled substances or any alcoholic beverages to the extent that the use impairs my ability to conduct with safety to the public the practice authorized by the license for which I am applying.

I hereby certify that I have read and subscribed to the Ethical Standards and Code of Conduct for Chemical Dependency Professionals prescribed by RIBCCDP.

– I authorize RIBCCDP/RILBCDP, its members, officers and employees, to investigate my background as it relates to the statements contained in my application and further consent to the release of information by third parties to RIBCCDP/RILBCDP which information relates directly to my application and statements contained therein so long as said information remains confidential.

– I further agree to hold RIBCCDP/RILBCDP, its members, officers, employees and examiner’s harmless and free from all liability from complaints, causes of action, suits, claims, demands and damages of every nature or kind pertaining or arising out of or relating in any manner whatsoever to actions taken by RIBCCDP/RILBCDP in investigating my application and making a determination regarding my certification.

– I further authorize the RIBCCDP/RILBCDP to release all documentation/information of application for certification/renewal along with all documentation of ethics complaints, Disciplinary Hearings, and disciplinary sanctions taken against me to the Department of Health, the ICRC/AODA and the Rhode Island Board of Licensing for Chemical Dependency Professionals.

I have read and understand the above.

Print Name

Witness

Signature

Date

Address

City, State, Zip Code

CLINICAL SUPERVISOR'S EVALUATION FORMS:

I have given the Clinical Supervisor's Evaluation Form to the following Clinical Supervisors.

Name: _____
Telephone #: _____
Name of Agency: _____
Mailing Address: _____

Name: _____
Telephone #: _____
Name of Agency: _____
Mailing Address: _____

Name: _____
Telephone #: _____
Name of Agency: _____
Mailing Address: _____

PROFESSIONAL REFERENCES:

I have requested the following individuals to forward their recommendations to RIBCCDP (Please list three (3) people, other than your supervisors, who know you PROFESSIONALLY and can attest to your PROFESSIONAL SKILLS). Provide your references with a copy of pages 8 to 10. Enclose and envelope addressed to RIBCCDP.

Name: _____
Address: _____
Telephone #: _____

Name: _____
Address: _____
Telephone #: _____

Name: _____
Address: _____
Telephone #: _____

PLEASE NOTE: The RIBCCDP reserves the right to request further information from all employers and other persons listed on the application form. The RIBCCDP and its review committees reserve the option to request an oral interview with the applicant. This information will be used strictly to evaluate the professional competence of a counselor and will be kept confidential by RIBCCDP. Further information may be requested in order to verify training, employment, etc. This information is not available to other persons without the written consent of the applicant.

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS
31 Smith Avenue - 3 Rear
Smithfield, Rhode Island 02917**

**CLINICAL SUPERVISOR'S REFERENCE FORM
CONFIDENTIAL**

Dear Clinical Supervisor:

Your employee named on the accompanying form is applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) and Rhode Island Board for Licensing of Chemical Dependency Professionals (RILBCDP) for certification/licensure as indicated below. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

Requirements for Clinical Supervisors:

Clinical Supervisor credentials:

- 1) Chemical Dependency Clinical Supervisor (CDCS/LCDS), or;
- 2) Master's degree in Behavioral Sciences with two (2) years clinical experience and documentation of 120 clock hours Substance Abuse Specific training. Included in this 120 clock hours must be 30 hours chemical dependency clinical supervisor education which includes training in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration & Treatment Knowledge, or;
- 3) LCDP/ACDP or LCDP/ACDP II with 30 clock hours Clinical Supervisor training. This training must include education in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration & Treatment Knowledge, or;
- 4) Ph.D. in Behavioral Science or M.D. with documentation of two (2) years of specialization/experience in the Chemical Dependency field, or;
- 5) Recognized Clinical Supervisor (RCS)

RIBCCDP believes that you, as a Clinical Supervisor, will have developed a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation together with those received from other references and the data furnished by the applicant will be used to determine eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

The Rhode Island Certification Board reserves the right to request further information from you concerning this applicant. Your cooperation will be very much appreciated in this certification effort.

Please return the completed evaluation along with documentation of the above requirements or a copy of your RCS certificate.

RIBCCDP
____ACDP II
____ACDP

CLINICAL SUPERVISOR'S EVALUATION FORM

APPLICANT: _____ DATE: _____

CLINICAL SUPERVISOR: _____

SUPERVISOR'S CREDENTIALS: _____

TELEPHONE #: _____ PROGRAM: _____

ADDRESS: _____

A. The following items represent the skills needed by a Chemical Dependency Professional. Evaluate the above named applicant as you feel he/she demonstrates their abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated skills.

PLEASE NOTE: Make your evaluations using the scale below.

- A rating of 1 is equivalent to NOT APPLICABLE
- 2 is equivalent to DON'T KNOW
- 3 is equivalent to POOR
- 4 is equivalent to AVERAGE
- 5 is equivalent to ABOVE AVERAGE
- 6 is equivalent to SUPERIOR

NOTE: The applicant must earn an average of 4 & be recommended by their supervisor to qualify for licensure.

1 2 3 4 5 6

{ } { } { } { } { } { } 1. **Screening-** The process by which a client is determined appropriate and eligible for admission to a particular program.

{ } { } { } { } { } { } 2. **Intake-** The administrative and initial assessment procedures for admission to a program.

{ } { } { } { } { } { } 3. **Orientation-** Describing the client:
- general nature and goals of the program;
- rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program;
- in a non-residential program, the hours during which services are available;
- treatment costs to be borne by the client, if any, and
- client's rights.

{ } { } { } { } { } { } 4. **Assessment-** Those procedures by which a counselor/program identifies and Evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment program.

{ } { } { } { } { } { } 5. **Treatment Planning-** Process by which the counselor and the client:
- identify and rank problems needing resolution;
- establish agreed upon immediate and long term goals, and;
- decide on the treatment methods and resources to be used.

Individual

1 2 3 4 5 6

{ } { } { } { } { } { } 6. **Counseling-** (Individual, Group & Significant Others) - The utilization of special skills to assist individuals, families or groups in achieving objectives through:

Group

{ } { } { } { } { } { } -exploration of a problem and its ramifications

Significant

-examination of attitudes and feelings;

Others

-consideration of alternative solutions, and;

{ } { } { } { } { } { }

-decision making.

1 2 3 4 5 6

{ } { } { } { } { } { } 7. **Case Management-** Activities which bring services, agencies, resources of people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

{ } { } { } { } { } { } 8. **Crisis Intervention-** Those services which respond to an alcohol/other drug abuser's needs during acute emotional/physical distress.

{ } { } { } { } { } { } 9. **Client Education-** Provision of information to individuals and groups, concerning Alcohol and other drug abuse and the available services and resources.

{ } { } { } { } { } { } 10. **Referral-** Identifying the needs of a client that cannot be met by the counselor or agency and assisting that client to utilize the support systems and community resources available.

{ } { } { } { } { } { } 11. **Reports & Recordkeeping-** Charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries and other client- related data.

{ } { } { } { } { } { } 12. **Consultation-** Relating with counselors and other professionals in regard to the client treatment (services) to assure comprehensive quality care for the client.

{ } { } { } { } { } { } 13. **Relapse Prevention,** discharge planning, follow-up and aftercare.

B. Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationships with clients:

1 2 3 4 5 6

{ } { } { } { } { } { } 1. Respect for the client.

{ } { } { } { } { } { } 2. Care and concern for the client.

{ } { } { } { } { } { } 3. Genuineness with client.

{ } { } { } { } { } { } 4. Empathy with client

{ } { } { } { } { } { } 5. Flexibility with client.

{ } { } { } { } { } { } 6. Judgment with client.

{ } { } { } { } { } { } 7. Spontaneity with client.

{ } { } { } { } { } { } 8. Capacity for confrontation with client.

{ } { } { } { } { } { } 9. Capacity for appropriate self-disclosure.

{ } { } { } { } { } { } 10. Sense of immediacy.

{ } { } { } { } { } { } 12. Ability to set appropriate boundaries.

c. EVALUATORS STATEMENT

Where did you receive your training in counseling?

How long have you been employed by this program?

Professional certificates or license you hold _____

Are you involved in the administration/management of the program at which you are employed?

- a) no
 b) Yes, limited to clinical aspects (i.e., supervision of counselors)
 c) Yes, limited to administrative responsibilities such as budgeting.
 d) Yes, both clinically and administratively

What is/was the overall size of his/her substance abuse case-load?

Average number of hours per week applicant worked in substance abuse specific individual counseling?

Average number of hours applicant worked in substance abuse specific group counseling?

Average number of hours applicant worked in substance abuse specific family counseling?

Average number of hours per week applicant worked in other significant and related substance abuse activities?

Describe: _____

Total number of hours per week applicant spent providing substance abuse specific services _____

For what period of time, have you provided substance abuse specific supervision for this applicant?

From _____ to _____

Comments/additional information you feel may be pertinent:

I HEREBY CERTIFY THAT I HAVE BEEN IN A POSITION TO OBSERVE AND HAVE FIRSTHAND KNOWLEDGE OF _____'S WORK AT _____

(Name of Counselor)

(Name of Working Setting)

I recommend this applicant for certification

I have some reservations in recommending this applicant:

I do not recommend this applicant.

I hereby certify that all of the above materials is, to the best of my knowledge, true.

Signature

Agency

Title

Date

PLEASE SUBMIT DOCUMENTATION OF THE REQUIRED CREDENTIALS AS STATED ON PAGE 16.

DO NOT RETURN THIS FORM TO APPLICANT - PLEASE RETURN TO THE BOARD.

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS**

**31 Smith Avenue - 3 Rear
Greenville, Rhode Island 02828**

R.I Certification Board:

ACDP II - Advanced Chemical Dependency Professional II
ACDP - Advanced Chemical Dependency Professional

**Professional Reference Form
Confidential**

Dear : _____:

I am applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) and Rhode Island Board for Licensing of Chemical Dependency Professionals (RILBCDP) for licensure as indicated below. References must be included as part of the application. Please complete the reference material enclosed and return it to the Board.

Your prompt attention to this would be very much appreciated as my application will not be processed until the Board receives this recommendation from you.

Sincerely,

(Signature of applicant)

RIBCCDP believes that licensure should be based on input from a variety of sources, especially the observations of persons who have known the applicant professionally. For this reason, all applicants are required to list three references who will complete this Professional Reference Form. Your evaluation together with those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

Please return the completed evaluation within one week to the Board. Your cooperation will be very much appreciated.

Sincerely,

The Rhode Island Board For The Certification
Of Chemical Dependency Professionals

____ACDP II
____ACDP

PROFESSIONAL REFERENCE FORM

Applicant's Name: _____

The following areas represent skills and knowledge needed by a Licensed Chemical Dependency Professional. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated ability.

- A rating of 1 is equivalent to NOT APPLICABLE
- 2 is equivalent to DON'T KNOW
- 3 is equivalent to POOR
- 4 is equivalent to AVERAGE
- 5 is equivalent to ABOVE AVERAGE
- 6 is equivalent to SUPERIOR

1 2 3 4 5 6

- 1. Common sense in dealing with client.
- 2. Respect for client.
- 3. Empathy with client.
- 4. Care and concern for client
- 5. Flexibility with clients.
- 6. Spontaneity with client.
- 7. Capacity for confrontation with client.
- 8. Capacity for appropriate self-disclosure.
- 9. Concreteness.
- 10. Ability to treat client information in accordance with state and federal confidentiality regulations.
- 11. Ability to communicate effectively with client and co-workers.
- 12. Knowledge of the Chemical Dependency field.
- 13. Capacity to act in an ethical manner with client.
- 14. Problem recognition and evaluation: Ability to apply knowledge of physical, behavioral, attitudinal and effective manifestations of substance abuse to determine its existence and degree of progression.
- 15. Counseling: Ability to facilitate appropriate change in client with regard to mood-altering, chemical substances.
- 16. Ability to set appropriate limits with clients.

GENERAL REMARKS:

Person completing Reference:

Your Name: _____

Address: _____
of Street City State Zip

Telephone#:(____)_____

Position: _____

I have known _____ for _____ years.
(Name of Applicant)

My relationship with him/her was/is _____

I hereby certify that this rating is, to the best of my knowledge, truthful and reflects as accurately as possible my knowledge of the applicant.

Signature: _____

PLEASE NOTE: APPLICANTS MUST EARN AN AVERAGE OF 4 TO QUALIFY FOR CERTIFICATION.

PHOTOCOPY FORMS AS NEEDED

PLEASE RETURN THIS FORM TO THE BOARD

PROFESSIONAL EXPERIENCE RESUME

Begin with your most recent employment and work backward. Include relevant military service.

EMPLOYER: _____

TYPE OF INSTITUTION/ESTABLISHMENT: _____

FULL ADDRESS: _____

NAME OF IMMEDIATE SUPERVISOR: _____

SUPERVISOR'S POSITION: _____

TITLE OF YOUR POSITION: _____

HRS. PER WEEK _____ FROM // TO //

YOUR DUTIES AND SPECIALTY: _____

EMPLOYER: _____

TYPE OF INSTITUTION/ESTABLISHMENT: _____

FULL ADDRESS: _____

NAME OF IMMEDIATE SUPERVISOR: _____

SUPERVISOR'S POSITION: _____

TITLE OF YOUR POSITION: _____

HRS. PER WEEK _____ FROM // TO //

YOUR DUTIES AND SPECIALTY: _____

PLEASE PHOTOCOPY THIS FORM AS NEEDED

**EXECUTIVE PROGRAM DIRECTOR
EXPERIENCE VERIFICATION FORM FOR ACDP II & ACDP APPLICANTS**

I _____ herein certify that _____ has been employed **within the past five (5) years** as a chemical dependency counselor **, at

for _____ hours*, from _____ to _____.

I _____ herein certify that _____ has been employed **prior to the past five (5) years** as a chemical dependency counselor **, at

for _____ hours*, from _____ to _____.

This facility is licensed/accredited/recognized by: _____ as
a _____ effective as of _____.
Date

Signature

Date

***hours must be documented cumulatively (total of hours worked)
**describes a principle job function. Principle function
must be chemical dependency counselor.**

PLEASE PHOTOCOPY AS NEEDED
ATTACH OFFICIAL JOB DESCRIPTION FROM FACILITIES WHERE EXPERIENCE
IS SUBMITTED FOR CREDIT

TABLE II
TRAINING AND EDUCATION RESUME

A. Substance Abuse Specific Training:

#	TRAINING	DATE ATTENDED	CLOCK HOURS
1	Confidentiality of Drug & Alcohol Client Records (Required)		12
2	Ethics (required)		6
3	HIV/AIDS Curriculum based risk reduction RIBCCDP approved (Required)		6
4	12 Hours Medication Assisted Therapy & Attitudes of Medication in the Recovery Process (Will be required as of (6/1/2008))		12
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
		TOTAL HOURS	_____

**TABLE II
TRAINING AND EDUCATION RESUME**

B. Counselor Training in Knowledge/Skill Base Performance Domains:

#	TRAINING	DATE ATTENDED	CLOCK HOURS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
			TOTAL HOURS _____

TABLE III

The requirements, as outlined, are by group clusters of Core Functions. This grouping of skills acquisitions recognizes that employment sites segment the counselor Core Functions into specific job descriptions. However, the well-rounded counselor will have had minimum supervision in each of the four groups.

"NOTE: A minimum of 20 hours are required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP II/ACDP must be 300."

	<u>ACDP II/ACDP</u>
<u>GROUP A</u>	
Screening	
Intake	80
Orientation	HRS.
Assessment	
<hr/>	
<u>GROUP B</u>	
Treatment Planning	120
Counseling	HRS.
Case Management	
Crisis Intervention	
<hr/>	
<u>GROUP C</u>	
Client Education	
Referral	40
	HRS.
<hr/>	
<u>GROUP D</u>	
Reports and	
Recordkeeping	60
Consultation	HRS.
Relapse prevention, discharge planning, follow-up and aftercare.	
<hr/>	

TOTALS: 300 hrs.

"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP II/ACDP must be 300."

CLINICAL SUPERVISION RECEIVED

CORE FUNCTIONS	# HOURS	Clin.Sup. Initials
-----------------------	----------------	---------------------------

GROUP A:

Screening - The process by which a client is determined appropriate and eligible for admission to a particular program.

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

Intake - The administrative and initial assessment procedures for admission to a program.

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

Orientation - Describing to the client: -general nature and goals of the program;
 -rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program
 -in a non-residential program, the hours during which services are available;
 -treatment costs to be borne by the client, if any, and; client's rights.

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

Assessment - Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan.

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

GROUP B:

Treatment Planning - Process by which the counselor and the client: identify and rank problems needing resolution; establish agreed upon immediate and long term goals, and; decide on the treatment methods.

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

Counseling - (Individual, Group & Significant Others) The utilization of special skills to assist individuals, families or groups in achieving objective through: exploration of a problem and its ramifications ; examinations of attitudes and feelings; consideration of alternative solutions, and; decision making

	<u> </u> (#Hrs)	<u> </u> (Clin. Sup Initials)
--	--	--

T
TOTAL HOURS _____

Supervisor's Signature _____ Date: _____

"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP ii?ACDP must be 300."

CORE FUNCTIONS	CLINICAL SUPERVISION RECEIVED #HOURS	Clin.Sup. Initials
Case Management - Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.	_____ (#Hrs)	_____ (Clin. Sup Initials)
Crisis Intervention - Those services which respond to an alcohol/drug abuser's needs during acute emotional and/or physical distress.	_____ (#Hrs)	_____ (Clin. Sup Initials)
GROUP C: Client Education - Provision of information to individuals and groups, concerning alcohol and other drug abuse and the available services and resources.	_____ (#Hrs)	_____ (Clin. Sup Initials)
Referral - Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems community resources available.	_____ (#Hrs)	_____ (Clin. Sup Initials)
GROUP D: Reports and Recordkeeping - Charting the results of the assessments and treatment plan; writing reports, progress notes, discharge summaries and other client-related data.	_____ (#Hrs)	_____ (Clin. Sup Initials)
Consultation - Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive quality care for the client.	_____ (#Hrs)	_____ (Clin. Sup Initials)
Relapse Prevention , discharge planning, follow up and aftercare.	_____ (#Hrs)	_____ (Clin. Sup Initials)

TOTAL HOURS: _____

Supervisor's Signature _____ Date: _____

COMMITTEE ON SPECIAL NEEDS

The Committee on Special Needs was established by the Rhode Island Board for the Certification of Chemical Dependency Professionals in September, 1992, to address and comply with those relevant sections and articles of the American's with Disabilities Act of 1990 (ADA) as they pertain to the RIBCCDP's credentialing and certification/licensure process. The Committee will strive to ensure access to the certification process to all applicants and maintain its certification standards. To this end, the Committee on Special Needs has set forth the following protocol:

1. All portfolios for all credentialed disciplines will include both the statement of need for special accommodations and medical release and/or other source, effective May 1, 1993. The Board shall be responsible for approving these forms, and the Committee will be responsible for ensuring that they are included in all portfolios. The Committee shall be responsible for updating these forms as needed, subject to Board approval.
2. Applicants will be required to submit the request for special accommodations to the Board no less than sixty days prior to the date designated for the administration of the appropriate examination.
3. Applicants will be required to submit the medical release and supporting documentation with the portfolio application by the designated deadline (forty-five days prior to the examination).
4. The Board's Administrative Staff will be responsible for referring all requests for special accommodations to the Committee on Special Needs. The Committee will Approve/Disapprove requests for special accommodations on a case-by-case basis, utilizing the judgment and discretion of the Committee to determine whether the applicant is an "individual with a disability" within the meaning of the ADA and whether the accommodations requested by the applicant are reasonable. A requested accommodation can only be refused if it would fundamentally alter the measurement of the skills or knowledge the exam is intended to test or would result in an undue burden. In cases where a request is denied, the Committee will convey this information to the Board for its consideration and final determination. The Committee shall refer any request to the Board, for accommodations that exceed reasonable financial responsibility in compliance with criteria established by the ADA.
5. The Committee will be responsible for approving the request and making the reasonable accommodations for each of the individual situations. This will include the contracting of interpreters and scribes, as well as securing the necessary equipment. The Committee will establish a comprehensive resource list to facilitate this process.
6. The Committee shall be responsible for ensuring that reasonable accommodations are indeed provided where approved and work with the Quality Assurance Committee to ensure that the standards and criteria of the credentialing process are upheld.
7. Applicant appeals and/or grievances will be directed to the Board for its action to be addressed through the Board's existing procedures.
8. This Board reserves the right to seek legal counsel when necessary for clarification of the ADA law or legal action on the part of an applicant has been indicated.
9. All requests for accommodations and any supporting documentation or medical information must be kept strictly confidential.

Policies for the Written Examination:

- 1) All translators must be approved by the Board, must not be a friend, relative or co-worker of the applicant and must be able to speak the "standard" language.
- 2) All translators must follow the exact protocol set forth by the ICRC/AODA for administration of all tests.
- 3) Translators role is simply to read, not interpret, what is presented; interpretation of questions is inappropriate.

Questions may be repeated if necessary.

4) Translation of questions read is audiotaped.

5) Test is proctored in "standard" language.

6) Time is extended according to ICRC/AODA guidelines.

7) Applicants who request the written examination be translated into their native language must pay all fees incurred. In addition, the applicant must choose an organization approved by the Board to provide this service.

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS**

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your request for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Also please supply any documentation (e.g., letter from a physician or other professional, evidence of a prior diagnosis or accommodation, etc.) which support this request.**

NAME: _____

ADDRESS: _____

PHONE#: _____ **S.S.#:** _____

ACCOMMODATIONS REQUESTED FOR THE _____ EXAMINATION

PLEASE CHECK ALL THAT APPLY:

- ____ Accessible Testing Site
- ____ Reader as accommodation for visual impairment
- ____ Scribe as accommodation for visual or motor impairment
- ____ Scribe as accommodation for learning disability
- ____ Extended time
 - ____ Time-and-a-half
 - ____ Double time
 - ____ More than double time (specify): _____

- ____ Separate testing area
- ____ Translator (specify standard language) _____

____ Other: _____

Comments:

Signed: _____ **Date:** _____

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS**

CONSENT FOR THE RELEASE OF HEALTH CARE INFORMATION

Applicant's Name: _____

Date of Birth: _____

I, _____, hereby authorize
_____ to
(Name and Address of Health Care Provider)

disclose and release to the Rhode Island Board for the Certification of Chemical Dependency Professionals, 31 Smith Avenue - 3 Rear, Greenville, Rhode Island 02828, all health care information relevant to the accommodation request made in the attached Accommodation Request Form which is incorporated herewith including, but not limited to, diagnoses and recommendations as to accommodations. This information is needed for the purpose of reviewing my request for accommodation in taking a certification examination.

I understand that I may revoke this consent at any future time in writing and that this consent expires upon completion of the certification process, or two years from the date of this release, whichever is earlier.

Signature of Applicant

Date