

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

EXECUTIVE PROGRAM DIRECTOR'S STATEMENT

I, _____ herein certify that
_____ has been employed as a chemical dependency clinical
supervisor, at _____
for _____ hours*, from _____ to _____ .

____ I recommend this applicant for Chemical Dependency Clinical Supervisor Certification.

(Signature of applicant's Program Director)

*hours must be documented cumulatively - must document 4,000 hours.

CLINICAL SUPERVISOR'S VERIFICATION

I, _____ herein certify that _____ has provided 200
Contact hours of face-to-face clinical supervision and has received 60 hours of face-to-face clinical supervision in
the Performance Domains and Tasks of a Clinical Supervisor.

____ I recommend this applicant for Chemical Dependency Clinical Supervisor Certification.

(Signature of applicant's Clinical Supervisor) (Date)

(Clinical Supervisor must submit a copy of transcripts documenting Advanced degree in Human Services or CDCS
certificate)

WORK EXPERIENCE:

List positions in order, beginning with most recent. Include dates, job title, duties, supervisor, where worked and why left. Use the three most recent positions.

Dates: _____

Job Title: _____

Where worked: _____

Supervisor: _____

Description of Duties: _____

Dates: _____

Job Title: _____

Where Worked: _____

Supervisor: _____

Description of Duties: _____

DOCUMENTATION OF REFERENCES

Please fill in the names and addresses of persons who have been asked to forward letters of reference on your behalf:

Current or Former
Clinical Supervisor _____

Two Current or
Former Supervisees _____

SPECIFIC TRAINING REQUIREMENTS

Training requirement must be validated. If you have taken the DATA course but do not have a certificate, contact the DATA Training Officer, who has complete training records and request that a copy is sent to you. This is true for all DATA courses. If you choose to submit an alternate educational or experiential situation for Board consideration, please be sure that its content is equivalent to or greater than that training offered by the Drug and Alcohol Treatment Association.

Attach DATA Certificate, or write a description of alternate academic course or training and attach validation to your application. Validation must be a transcript, a certificate of completion, or a supervisor or trainer's endorsement. Include date, place of training, and instructor's name.

Clinical Supervision * (Please check off a or b below)

- a. _____ DATA Certificate attached

- b. _____ Alternate Education or Alternate Training. (Please check off and validate equivalent experience for each item listed.)

DATA SYNOPSIS OF CLINICAL SUPERVISION VALIDATED ALTERNATE TRAINING

Please describe course outline of alternate training on lines provided below:

The primary focus of the course is toward the supervision of workers who provide direct clinical services, such as the various forms of counseling, to clients in substance abuse treatment programs.

The course is designed to provide knowledge, understanding, and skill in supervision and its related areas to persons who have clinical or other supervisory responsibilities in drug abuse or other treatment settings.

Clinical supervision is defined in this course as "those structural relations and procedures designed for the purpose of planning, oversight, monitoring, and evaluation of the activities of the staff to ensure conformance with agency/program policy and to ensure high quality service to clients." The course is directed toward the generic elements of supervision, with major attention given to the administrative (organizational) and the clinical (teaching/learning) aspects of supervision in substance abuse.

Major emphasis is placed on the conceptual and functional definition of supervision, the organizational context in which supervision occurs, the supervisor as the role relates to administrative and clinical aspects of supervision, selected models of supervision, selected tools for supervision, and the skills required for effective execution of the supervisory role.

Clinical Supervisor's or Clinical Trainer's Endorsement
(When applicable)

CHEMICAL DEPENDENCY CLINICAL SUPERVISOR

APPLICATION CHECK LIST

- _____ 1. Advanced Chemical Dependency Professional II, Advanced Chemical Dependency Professional, Certified Co-Occurring Disorder Professional or Certified Co-Occurring Disorder Professional-Diplomate.

- _____ 2. Verification of two years (4,000 hours) of clinical supervisory experience in the AODA field, in an approved licensed program beyond the three years (6,000 hours) submitted for Advanced Chemical Dependency Professional licensure. These two (2) years must include the provision of 200 contact hours of face-to-face clinical supervision, which were under the direct supervision of an individual with an Advanced degree in Human Services, or CDCS, of which 60 hours must be face-to-face Clinical Supervision.

- _____ 3. Fifty percent (50%) of the experience must be gained within five (5) years prior to application.

- _____ 4. A formal job description on facility letterhead must be submitted from facilities verifying experience. Please note that an acceptable job description must state that you provided Clinical Supervision along with performing all the Domains and Tasks of a Clinical Supervisor..

- _____ 5. Experience Verification from Program Director and Clinical Supervisor's verification of provision of 200 contact hours of clinical supervision along with receiving 60 hours clinical supervision in the Performance Domains and Tasks

- _____ 6. References as follows:
 - a. At least one current or previous supervisor
 - b. At least two supervisees

- _____ 7. At least 30 hours of Clinical Supervision Workshop, or a completed 3 credit course approved by the Board. This must include training in each of the following areas: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration & Treatment Knowledge.

- _____ 8. Successful completion of 6 Hrs. Chemical Dependency Counselor Ethics Training.

- _____ 9. Applicants must submit Evaluation forms along with a written narrative completed by their Clinical Supervisor of each facility verifying experience.

- _____ 10. Signed Ethics Code

- _____ 11. Completed application.

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

**31 Smith Avenue - 3 Rear
Greenville, RI 02828**

**ITEMS TO BE COVERED IN EVALUATION OF APPLICANT FOR CLINICAL SUPERVISOR
CERTIFICATION**

Supervisor's Name: _____

Program: _____

Evaluator(s) Name(s): _____

Date of Evaluation: _____

Instructions:

1. A written evaluation is required which covers the following category using separate heading for each:

- I. Ability to facilitate learning
- II. Supervisory intervention skills
- III. Personal and professional development
- IV. Ability to be a role model
- V. Ability to directly teach theory and practice
- VI. Administrative-managerial abilities

2. The attached material lists the kinds of competencies considered important under each heading. There is also room in each section to add items of your own. The supervisor should know your view on each item, and the write-up for each section should reflect your integration statement of where he/she stands on each dimension. A scale is provided to assist you in rating each competency, and to facilitate feedback and discussion with the applicant. Please assign a score to each competency.
3. If there are disagreements, a statement about the issue, written by the supervisor, must appear at the end of the evaluation. This is to be followed by a written response by you.
4. The evaluation must be signed by both the applicant and the evaluator(s) indicating that the evaluation has been shared and is agreeable to both parties.

Partially adapted from the Franklin County Mental Health Center's Supervisor Performance evaluation form.

Competency Scale:

NI - Not enough information

1 - Unsatisfactory

2 - Satisfactory, But needs improvement

3 - Satisfies requirements

4 - Exceeds requirements

1. Ability to facilitate learning

- 1. Able to minimize threat, resistance, defensiveness
- 2. Commitment to teaching, involvement in providing quality supervision, sees supervision as a priority.
- 3. Able to give emotional support.
- 4. Utilizes a variety of supervisory methods/tools (e.g., process recording, audio recording, direct observation, case conferences, etc.)
- 5. Able to transmit knowledge effectively
- 6. Attempts to explain the concepts relevant to the handling of a case rather than the specifics of what the counselor should do.
- 7. Makes appropriate recommendations to counseling staff as to specific training and staff development needs.
- 8. Is responsive to differing point of view
- 9. Other:

2. Supervisory Intervention Skills

- 1. Demonstrates ability to assess when to offer assistance, when to leave the problem with the counselor, and when to suggest the use of other agency resources in the interest of the client.
- 2. Able to handle disagreements in supervision
- 3. Able to work out differences with supervisee-supervisory style
- 4. Able to use therapeutic interventions when indicated.
- 5. Aware of the interpersonal dynamics of supervisory relationship.
- 6. Able to diagnose and respond to supervisee's learning needs.
- 7. Able to diagnose and modify difficulties in the supervisory relationship.
- 8. Able to foster the personal growth of supervisee.
- 9. Sees supervision as a two-way learning and growth activity.
- 10. Encourages continuous processing of the supervisory relationship.
- 11. Able to be an ombudsperson and advocate for supervisee(s).
- 12. Ability to express feelings directly in supervision rather than concealing them/acting them out.
- 13. Ability to acknowledge own role in any supervisory difficulties.
- 14. Awareness of personal issues affecting response to the material supervisee's clients present.
- 15. Offers complimentary evaluative feedback in a sensitive and effective manner.
- 16. Offers corrective evaluative feedback in a sensitive and effective manner.
- 17. Communicates complimentary feedback in a clear and concise manner.
- 18. Communicates corrective feedback in a clear and concise manner.
- 19. Other:

3. Personal and Professional Development

- 1. Level of interest in working on own personal growth.
- 2. Level of interest in continuous professional development.
- 3. Responsibility in meeting supervisory duties (providing time according to Training Committee Guidelines, promptness, in keeping supervision appointment, etc.)
- 4. Awareness of limitations in supervisory skills.
- 5. Awareness of strengths in supervisory skills.
- 6. Uses authority appropriately.
- 7. Has sufficient competence in clinical casework to facilitate work of counseling staff.
- 8. Capable of assessing the performance and the professional development of casework staff.
- 9. Other:

4. Ability to be a role model

- ___1. Level of influence
- ___2. Able to model growthful attitudes towards clients when discussing their material.
- ___3. Promotes attitude of accountability regarding outcome of clinical work, ethical standards, etc.
- ___4. Other:

5. Ability to directly teach theory and practice

- ___1. Able to teach assessment skills
- ___2. Able to teach an integrated treatment approach.
- ___3. Able to communicate theoretical formulations.
- ___4. Able to teach a development of treatment plan.
- ___5. Able to teach understanding of assessment and therapy interventions as a process.
- ___6. Able to provide effective case-oriented supervision.
- ___7. Able to teach general principles of growth and change.

6. Administrative-Managerial Abilities

- ___1. Addresses issues of adequacy and quality of case records.
- ___2. Appears to be knowledgeable of general concerns, issues, and trends reflected in agency's case load.
- ___3. Demonstrates appropriate endorsement of agency policy and procedure.
- ___4. Other:

Applicant's signature: _____

Evaluator(s) Signature(s): _____

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 disclose and release to
the Rhode
(Name and Address of Health Care Provider)

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