

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

**31 Smith Avenue - 3 Rear
Greenville, RI 02828
(401) 349-3822
ricert@msn.com
www.ribccdp.com**

APPLICATION FOR

**PROVISIONAL CERTIFIED CO-OCCURRING DISORDER PROFESSIONAL
PCCDP - Starting March 1, 2008**

**CERTIFIED CO-OCCURRING DISORDER PROFESSIONAL
CCDP (After May 29, 2008)**

**CERTIFIED CO-OCCURRING DISORDER PROFESSIONAL-DIPLOMATE
CCDP-D (After May 29, 2008)**

UPDATED 2/25/2008

PLEASE NOTE: Applicants are responsible to utilize the MOST RECENT application uploaded to the RIBCCDP website. Outdated applications will NOT be accepted.

Application fees:

PCCDP	\$125.00
CCDP	\$225.00
CCDP-D	\$225.00

**THIS APPLICATION CAN BE UTILIZED FOR PCCDP CERTIFICATION STARTING MARCH 1,
2008.**

**ALL CCDP & CCDP-D APPLICANTS CAN UTILIZE THE TRANSITION APPLICATION FROM
MARCH 1, 2008 THROUGH MAY 29, 2008.**

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PLEASE CHECK ONE: _____ **CCDP-D** _____ **CCDP** _____ **PCCDP**

NAME (Print Clearly) _____

HOME ADDRESS: _____

_____ (city) _____ (state) _____ (zip)

HOME PHONE: () _____ WORK PHONE: () _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ ZIP CODE: _____

HIGHEST DEGREE EARNED: _____ NAME OF COLLEGE/UNIVERSITY: _____

NAME ON YOUR TRANSCRIPT, if different than listed above (i.e. maiden name) _____

YOUR SIGNATURE: _____ DATE: _____

Optional Information:

Race: ___Caucasian ___Black/Afro American ___Asian ___Hispanic ___American Indian/Alaskan Native ___Other

Testing Date Requested: ___March ___June ___September ___December

Please note: When selecting TEST DATES, applicants must take the written examination on the test date selected. The RIBCCDP is charged \$70.00 for each written examination ordered whether it is used or not. If an applicant does not take the written examination on the test date they have selected, a test fee of \$70.00 will be required to sit for the next test date.

To be completed by IC&RC Member Board:

I verify that the certification of the applicant named above is in good standing with the RIBCCDP.

The credential is a _____ due to next renew on _____.

Signature of Board Representative

Date

Check one:

___ICADC ___ICAADC ___ICCS ___ICPS ___ICCJP ___ICCDP-D ___ICCDP
(Counselor) (Adv.Counselor) (Clinical Sup) (Prevention) (Criminal Justice) (Co-Occur.Dip) (Co-Occurring)

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 18 to 20. Enclose an 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.

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

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.

1) Have you ever applied for certification/licensure as a Co-Occurring Disorder Professional in another state ?
____yes ____no

2) 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 I have read and subscribed to the Ethical Standards and Code of Conduct for Co-Occurring Disorder Professionals prescribed by RIBCCDP.

-I authorize RIBCCDP, 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 which information relates directly to my application and statements contained therein so long as said information remains confidential.

-I further agree to hold RIBCCDP, 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 in investigating my application and making a determination regarding my certification.

-I further authorize the RIBCCDP 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 Mental Health, Retardation & Hospitals, Department of Health and ICRC/AODA.

I have read and understand the above.

Print Name

Witness

Signature

Date

Address

City, State, Zip Code

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

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

**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) for certification as a Co-Occurring Disorder Professional.

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.

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 your credentials.

Sincerely,

The Rhode Island Board For The Certification
Of Chemical Dependency Professionals

____ CCDP –D

____ CCDP

____ PCCDP

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 Co-Occurring Disorder 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 Co-Occurring Certification.

1 2 3 4 5 6

{ } { } { } { } { } { } 1. Screening & Assessment

- Ability to engage client and establish a rapport.
- Ability to gather and document client information.
- Ability to recognize signs & symptoms of substance abuse disorders & psychiatric disorders.
- Ability to recognize interactions between co-existing mental, substance-related and medical disorders.
- Develop diagnostic impressions and communicate results.

{ } { } { } { } { } { } 2. Crisis Prevention & Management

- Ability to conduct an immediate risk assessment to determine the existence of an emergency or crisis situation.
- Ability to evaluate the nature and level of risk in a client's crisis situation by analyzing the elements of the crisis in order to implement and provide an appropriate intervention.
- Ability to implement an immediate course of action appropriate to the crisis.
- Ability to conduct an in-depth debriefing with all parties involved with the crisis.
- Develop and implement an individualized follow-up plan.

{ } { } { } { } { } { } 3. Treatment & Recovery Planning

- Ability to interpret and evaluate clinically relevant data received from individual, significant others, assessments, and prior treatment sources to determine treatment needs.
- Engage the individual and others in a comprehensive treatment planning process.
- Ability to review data with the individual and others to collaboratively identify and prioritize treatment needs.
- Develop integrated treatment goals and measurable objectives with the individual and others.
- Ability to identify specific and measurable steps to achieve goals, utilizing the individual's strengths and resources.
- Ability to monitor and document individual's progress in achieving treatment goals, and modifying the treatment plan as necessary.

1 2 3 4 5 6

{ } { } { } { } { } **4. Counseling**

- Ability to provide a safe, empathetic environment in order to facilitate a collaborative relationship with the person and significant other.
- Develop an ongoing therapeutic alliance.
- Utilizes appropriate integrated counseling strategies and techniques.
- Ability to evaluate the effectiveness of counseling intervention strategies.
- Develop integrative discharge and aftercare plans.

{ } { } { } { } { } **5. Management & Coordination of Care**

- Ability to collaborate with the individual and others to identify and prioritize strengths and needs and match to appropriate services.
- Develop treatment and service options in a collaborative manner.
- Ability to access, coordinate, and facilitate referrals, community, peer and natural support systems to maximize treatment and recovery opportunities as identified in the comprehensive, integrated treatment plan.
- Ability to monitor and evaluate the delivery and coordination of services.

{ } { } { } { } { } **6. Education of the Person, their Support System & the Community**

- Ability to educate the person and family about the symptoms of specific disorders, their interactive effects, and the relationship between symptoms and stressors .
- Ability to educate the person and family about the recovery process.
- Ability to educate the person and family about self-help and peer groups in the recovery process.
- Ability to educate the person and family about self-advocacy.
- Ability to educate the community about co-occurring disorders, the impact on the individual, family, and community and the efficacy of treatment.

{ } { } { } { } { } **7. Professional Responsibility**

- Behaves in an ethical manner by adhering to multi-disciplinary codes of ethics and standards of practice.
- Ability to follow appropriate policies and procedures by adhering to federal, state, and agency regulations regarding substance use and mental health treatment as they relate to integrated care.
- Ability to recognize and maintain professional and personal boundaries.
- Ability to engage in continuing professional development based on an ongoing assessment of needs.
- Participation in clinical and administrative supervision and consultation.
- Ability to advocate for public policy and resource development in support of quality services.

C. SUPERVISOR'S STATEMENT

Where did you receive your training in Co-Occurring Disorders?

How long have you been employed by this program?

List Professional certificates or license you hold_____

C. SUPERVISOR'S STATEMENT - CONTINUED

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 Co-Occurring Disorder caseload? _____

For what period of time, have you provided 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 Applicant) (Name of Work 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 material is, to the best of my knowledge, true.

Signature

Agency

Title

Date

**PLEASE SUBMIT DOCUMENTATION OF YOUR CREDENTIALS
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:

Co-Occurring Disorder Professional

**Professional Reference Form
Confidential**

Dear : _____:

I am applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) for certification 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 certification 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 that 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

____ CCDP –D

____ CCDP

____ PCCDP

PROFESSIONAL REFERENCE FORM

Applicant's Name: _____

The following areas represent skills and knowledge needed by a Co-Occurring Disorder 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 DONT 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. Engage client and establish rapport.
2. Respect for client.
3. Empathy with client.
4. Care and concern for client.
5. Flexibility with client/clients.
6. Facilitate a collaborative relationship with client and significant other (s).
7. Behave in an ethical manner.
8. Recognize and maintain professional & personal boundaries.
9. Engage in continuing professional development.
10. Ability to treat client information in accordance with agency, state and federal confidentiality regulations.
11. Ability to communicate effectively with client and co-workers.
12. Knowledge of Co-Occurring Disorders.
13. Ability to receive clinical and administrative supervision & consultation.

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:_____ Date:_____

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 CO-OCCURRING APPLICANTS**

EXPERIENCE WITHIN THE PAST FIVE (5) YEARS):

I _____ herein certify that _____ has
(Executive Program Director) (Applicant's Name)

been employed **within the past five (5) years** as a behavioral health professional with experience and training in the integrated treatment of and interactive relationship between substance use and mental disorders, at

_____ for _____ hours*
(Name of agency) (Cumulative Hours worked)

from _____ to _____
(Employment Start date) (Employment End Date)

EXPERIENCE PRIOR TO THE PAST FIVE (5) YEARS:

I _____ herein certify that _____ has
(Executive Program Director) (Applicant's Name)

been employed **prior to the past five (5) years** as a behavioral health professional with experience and training in the integrated treatment of and interactive relationship between substance use and mental disorders, at

_____ for _____ hours*
(Name of agency) (Cumulative Hours worked)

from _____ to _____
(Employment Start date) (Employment End Date)

This facility is licensed/accredited/recognized by: _____

Signature

Date

***hours must be documented cumulatively (total of hours worked)**

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

TABLE II

TRAINING AND EDUCATION RESUME

B. CCDP: REQUIRED – 30 hours Addiction Specific Training
PCCDP: REQUIRED – 70 hours Addiction Specific Training

#	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

TRAINING AND EDUCATION RESUME

**B. CCDP: REQUIRED - 30 hours Mental Health Specific Training:
PCCDP: REQUIRED – 70 hours Mental Health Specific Training**

#	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 _____

PERFORMANCE DOMAINS
CLINICAL SUPERVISION RECEIVED

**"NOTE: CCDP-P - 100 hours total with minimum of 10 hours in each Domain.
CCDP - 200 hours total with a minimum of 20 hours in each Domain.
PCCDP - 150 hours total with a minimum of 10 hours in each Domain.**

Screening & Assessment:

- Engage client and establish rapport
- Gather and document client information
- Recognize signs and symptoms of substance use disorders
- Recognize signs & symptoms of psychiatric disorders
- Recognize interactions between co-existing mental, substance-related, and medical disorders
- Utilize relevant assessment instruments
- Develop diagnostic impressions and communicate results

Hours Supervised

Supervisor's Signature/Date

Crisis Prevention & Management

- Conduct an immediate risk assessment to determine the existence of an emergency or crisis situation
- Evaluate the nature and level of risk in a client's crisis situation by analyzing the elements of the crisis in order to implement and provide an appropriate intervention.
- Implement an immediate course of action appropriate to the crisis
- Conduct an in-depth debriefing with all parties involved with the crisis
- Develop and implement an individualized follow-up plan

Hours Supervised

Supervisor's Signature/Date

Treatment & Recovery Planning

- Interpret and evaluate clinically relevant data received from individual, significant others, assessments, and prior treatment sources to determine treatment needs
- Engage the individual and others in a comprehensive treatment planning process
- Review data with the individual and others to collaboratively identify and prioritize treatment needs
- Develop integrated treatment goals and measurable objectives with the individual and others
- Identify specific and measurable steps to achieve goals, utilizing the individual's strengths and resources
- Monitor and document individual's progress in achieving treatment goals, and modifying the treatment plan as necessary

Hours Supervised

Supervisor's Signature/Date

TOTAL HOURS: _____

PERFORMANCE DOMAIN
CLINICAL SUPERVISION RECEIVED
CONTINUED (page 2)

Counseling

- Provide a safe, empathic environment in order to facilitate a collaborative relationship with the person and significant other
- Develop an ongoing therapeutic alliance
- Utilize appropriate integrated counseling strategies and techniques
- Evaluate the effectiveness of counseling intervention strategies
- Develop integrative discharge and aftercare plans

Hours Supervised

Supervisor's Signature/Date

Management & Coordination of Care

- Collaborate with the individual and others to identify and prioritize strengths and needs and match to appropriate services
- Develop treatment and service options in a collaborative manner
- Access, coordinate, and facilitate referrals, community, peer and natural support systems to maximize treatment and recovery opportunities as identified in the comprehensive, integrated treatment plan
- Monitor and evaluate the delivery and coordination of services

Hours Supervised

Supervisor's Signature/Date

Education of the Person, their Support System & the Community

- Educate the person and family about the symptoms of specific disorders, their interactive effects, and the relationship between symptoms and stressors
- Educate the person and family about the recovery process
- Educate the person and family about self-help and peer groups in the recovery process
- Educate the person and family about self-advocacy
- Educate the community about co-occurring disorders, the impact on the individual, family, and community and the efficacy of treatment

Hours Supervised

Supervisor's Signature/Date

Professional Responsibility

- Behave in an ethical manner by adhering to multi-disciplinary codes of ethics and standards of practice
- Follow appropriate policies and procedures by adhering to federal, state, and agency regulations regarding substance use and mental health treatment as they relate to integrated care
- Recognize and maintain professional and personal boundaries
- Engage in continuing professional development based on an ongoing assessment of needs
- Participate in clinical and administrative supervision and consultation
- Advocate for public policy and resource development in support of quality services

Hours Supervised

Supervisor's Signature/Date

TOTAL HOURS: _____

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CHEMICAL DEPENDENCY PROFESSIONALS**

31 Smith Avenue - 3 Rear
Greenville, RI 02828
(401) 349-3822

**CODE OF ETHICS
AND
DISCIPLINARY PROCEDURES**

For Counselors In Training
Chemical Dependency Professionals
Provisional Chemical Dependency Professionals
Advanced Chemical Dependency Professionals
Advanced Chemical Dependency Professional II
Certified Criminal Justice Professionals
Chemical Dependency Clinical Supervisor
Recognized Clinical Supervisor
Student Assistance Counselors
Prevention Professionals
Co-Occurring Disorder Professionals

I have read and understand the RIBCCDP Code of Ethics and Disciplinary Procedures in its entirety.

I do accept all of the Principles of the Rhode Island Board for the Certification of Chemical Dependency Professionals' Code of Ethics and Disciplinary Procedures as prescribed by the RIBCCDP.

Signed: _____

Date: _____