R.I. BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS
PROVISIONAL CHEMICAL DEPENDENCY PROFESSIONAL

PORTFOLIO - GENERAL INFORMATION SHEET

I am applying for certification as a :

___ Provisional Certified Chemical Dependency Professional (PCDP)

****

1. Full Name:____
   First Middle Last (Maiden)

2. Residence Address:____
   Street City/Town State Zip Code

3. Mailing Address:____
   Street City/Town State Zip Code

4. Telephone Number: (Home) _________________________ (Work) ____________________________

5. Social Security Number: _________________________ Date/Place of Birth:_______________________

6. Highest Degree of: ______________________________ Granted By: _____________________________
   AS, BA, MSW, MS, MA, etc College or University

7. Other Colleges/Universities attended:
   College Dates Degree/Sem. Hrs. to Date Major

   ____

   ____

8. Have you ever been licensed/certified in any state?____
   If yes, give state(s), date of licensure, license number, current status, expiration date(s).

   ____

9. Have you ever been convicted of a felony violation of any state or federal law? ______
   If yes, explain by attachment.
   NOTE: Non-disclosure may be grounds for denial of licensure.

10. Optional Information:
    Race: ___Caucasian ____Black/Afro American __Asian ___Hispanic ___American Indian/Alaskan Native ___Other

PLEASE PHOTOCOPY THIS COMPLETED FORM AND RETAIN FOR YOUR OWN RECORDS.

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 20 to 22. 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.

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), and the Rhode Island Department of Health (RIDOH).

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, and RIDOH 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, and RIDOH 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, and RIDOH 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, and RIDOH in investigating my application and making a determination regarding my certification.

–I further authorize the RIBCCDP, RILBCDP, and RIDOH 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 by the Department of Health, the ICRC/AODA and the Rhode Island Board of Licensing for Chemical Dependency Professionals. Furthermore, I understand and acknowledge that any sanctions imposed against my LCDP/LCDCS by the RIBLCDP/RIDOH will also be imposed against my RIBCCDP issues certification(s).

I have read and understand the above.

Print Name:____________________________________ Witness:_________________________________

Signature:_____________________________________ Date:____________________________________

Address:______________________________________ City,State, Zip____________________________

APP#__________

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 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:

1) Licensed Chemical Dependency Clinical Supervisor (LCDCS), 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 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)

.

It is vital that you complete the Evaluation form accurately.

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 Clinical Supervisor requirements or a copy of your RCS certificate

Sincerely

RIBCCDP

_____PCDP

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 Provisional Certified 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 equalivent to NOT APPLICABLE

2 is equalivent to DON'T KNOW

3 is equalivent to POOR

4 is equalivent to AVERAGE

5 is equalivent to ABOVE AVERAGE

6 is equalivent to SUPERIOR

NOTE: The applicant must earn an average of 4 to qualify for certification.

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

{} {} {} {} {} {} 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 Others -examination of attitudes and feelings;

-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 ction 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. Genuiness 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 Applicant) (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 CLINICAL SUPERVISOR REQUIREMENTS AS NOTED ON PAGE 16 OR A COPY OF YOUR RCS CERTIFICATE.

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 08287

R.I Certification Board:

PCDP - Provisional Chemical Dependency 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 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 Certification of Chemical Dependency Professionals

_____PCDP

PROFESSIONAL REFERENCE FORM

Applicant's Name:____

The following areas represent skills and knowledge needed by a Provisional Certified Chemical Dependency Professional/Advanced Provisional Certified 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 equalivent to NOT APPLICABLE
2 is equalivent to DON'T KNOW
3 is equalivent to POOR
4 is equalivent to AVERAGE
5 is equalivent to ABOVE AVERAGE
6 is equalivent 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 PCDP APPLICANTS

I_______________________________herein certify that________________________________has been employed
(Program Director) (Name of Applicant)

within the past five (5) years as a chemical dependency professional **, at

____
(Name of Agency)

for ______________________hours*, from ______________to________________.
(Cumulative Hours)

****

I_______________________________herein certify that________________________________has been employed
(Program Director) (Name of Applicant)

prior to the past five (5) years as a chemical dependency professional **, at

____
(Name of Agency)

for ______________________hours*, from ______________to________________.
(Cumulative Hours)

****

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 Provisional Certified Chemical Dependency Professional__.

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 Clients Records (42 CFR, Part 2)) (REQUIRED)**		**12**
2	**Ethics (REQUIRED**)		**6**
3	**HIV/AIDS/Viral Hepatitis 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:

#	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 10 hours are required in each Core Function for PCDP. However, the total accumulated hours for PCDP must be 150."

	PCDP
GROUP A	
Screening Intake Orientation Assessment	40 HRS.
GROUP B	
Treatment Planning Counseling Case Management Crisis Intervention	60 HRS.
GROUP C	
Client Education Referral	20 HRS.
GROUP D	
Reports and Recordkeeping Consultation Relapse prevention, discharge planning, follow-up and aftercare.	30 HRS.

TOTALS: 150 hrs.

NOTE: A minimum of 10 hours is required in each Core Function for PCDP. However, the total accumulated hours for PCDP must be 150."

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.

________ ________________
(#Hrs) **(Clin. Sup Initials)**

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

________ ________________
(#Hrs) **(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.

________ ________________
(#Hrs) **(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.

________ ________________
(#Hrs) **(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.

________ ________________
(#Hrs) **(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

________ ________________
(#Hrs) **(Clin. Sup Initials)**

TOTAL HOURS___________

Supervisor’s Signature_______________________________Date:______________

"NOTE: A minimum of 10 hours is required in each Core Function for PCDP. However, the total accumulated hours for PCDP must be 150."

CLINICAL SUPERVISION RECEIVED

CORE FUNCTIONS **#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:______________

RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS

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

CODE OF ETHICS AND DISCIPLINARY PROCEDURES

For Counselors In Training
Provisional Chemical Dependency Professional
Chemical Dependency Professionals
Advanced Chemical Dependency Professionals
Advanced Chemical Dependency Professional II
Chemical Dependency Clinical Supervisor
Recognized Clinical Supervisor
Student Assistance Counselors
Prevention Professionals
Certified Criminal Justice Professional
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:___________________________________