

**APPLICATION FOR
R.I. BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY
PROFESSIONALS**

PORTFOLIO - GENERAL INFORMATION SHEET

I am applying for certification as: **Application Fee \$200.00 ALL LEVELS Non-Refundable**
 Certified Prevention Specialist
 Advanced Certified Prevention Specialist
 Certified Prevention Specialist Supervisor
 Integrated HIV/AIDS & Viral Hepatitis Specialty (Available for ALL Levels)

Please Note: Any level may apply for the Integrated HIV/AIDS & Viral Hepatitis Specialty providing all required curriculum is verified)

Name: _____
(Last Name) (First Name) (MI)

Home Address: _____

City County State Zip

Office Address: _____
Agency Number and Street

Mailing Address: _____

Telephone #: (w): _____ (h): _____

Social Security Number: _____ Email: _____

Optional Information:

Educational Level Completed:
_____ H.S. _____ Assoc of Arts/Science _____ BA/BS _____ MA _____ PhD.

Race:
_____ Caucasian _____ Black/Afro American _____ Asian _____ Hispanic _____ American Indian/Alaskan Native
_____ Other

Requested Test Language: Please check only one (May not be available)
_____ English _____ French _____ Spanish

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.

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

SUPERVISOR'S EVALUATION FORMS:

I have given the Supervisor's Evaluation Form to the following 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 10 through 12. Enclose an envelope addressed to RIBCCDP.

Name: _____

Telephone #: _____

Mailing Address: _____

Name: _____

Telephone #: _____

Mailing Address: _____

Name: _____

Telephone #: _____

Mailing Address: _____

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 prevention specialist and will be kept confidential by RIB CCDP. 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 issued certification(s).

I have read and understand the above.

Print Name: _____

Witness: _____

Signature: _____

Date: _____

Address: _____

City, State, Zip : _____

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

31 Smith Avenue - 3 Rear
Greenville, Rhode Island 02828

R.I. Certification Board:

**SUPERVISOR'S REFERENCE FORM
CONFIDENTIAL**

Dear 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.

RIBCCDP believes that you, as a 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. If a TASK Force or Board completes this Evaluation, we request that you convene an Executive session to complete these documents and submit a copy of your Board minutes to verify completion.

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

Please return the completed evaluation, to the Board.

Sincerely

The Rhode Board For The Certification
of Chemical Dependency Professionals

- ___ Certified Prevention Specialist
- ___ Advanced Certified Prevention Specialist
- ___ Certified Prevention Specialist Supervisor
- ___ Integrated HIV/AIDS & Viral Hepatitis Specialty

SUPERVISOR'S EVALUATION FORM

APPLICANT: _____ DATE: _____

SUPERVISOR: _____

SUPERVISOR'S CREDENTIALS: _____

TELEPHONE #: _____ PROGRAM: _____

ADDRESS:

A. The following items represent the skills needed by a Prevention Specialist. Evaluate the above named applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the individual'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 certification.

1 2 3 4 5 6

{ } { } { } { } { } { } 1. Monitor projects progression.

{ } { } { } { } { } { } 2. Identify financial sources and strategies.

{ } { } { } { } { } { } 3. Create needed materials.

{ } { } { } { } { } { } 4. Facilitate community awareness.

{ } { } { } { } { } { } 5. Facilitate capacity building.

{ } { } { } { } { } { } 6. Document project activities and outcomes.

{ } { } { } { } { } { } 7. Conduct training needs assessments.

{ } { } { } { } { } { } 8. Address educational needs of audience.

{ } { } { } { } { } { } 9. Provide relevant information.

{ } { } { } { } { } { } 10. Select ATOD prevention materials and resources.

{ } { } { } { } { } { } 11. Conduct training evaluations.

{ } { } { } { } { } { } 12. Provide prevention information to professionals in related fields.

{ } { } { } { } { } { } 13. Design and deliver culturally appropriate trainings.

{ } { } { } { } { } { } 14. Identify community stakeholders.

1 2 3 4 5 6

- { } { } { } { } { } { } 15. Assist consumers in identifying specific issues.
- { } { } { } { } { } { } 16. Consult with members of the community in conducting self assessments.
- { } { } { } { } { } { } 17. Establish a community network.
- { } { } { } { } { } { } 18. Construct a comprehensive prevention plan with community members.
- { } { } { } { } { } { } 19. Increase community involvement.
- { } { } { } { } { } { } 20. Facilitate development of local leadership.
- { } { } { } { } { } { } 21. Influence formal and informal policy to infuse prevention strategies.
- { } { } { } { } { } { } 22. Establish effective working relationships with media.
- { } { } { } { } { } { } 23. Plan public policy initiatives collaboratively.
- { } { } { } { } { } { } 24. Increase resources for prevention.
- { } { } { } { } { } { } 25. Inform policy makers of prevention program effectiveness.
- { } { } { } { } { } { } 26. Attain knowledge of current research-based prevention trends.
- { } { } { } { } { } { } 27. Model collaborative behavior with colleagues.
- { } { } { } { } { } { } 28. Practice ethical behavior to promote integrity of the profession.
- { } { } { } { } { } { } 29. Recognize community norms to be sensitive to the needs of the community.
- { } { } { } { } { } { } 30. Practice personal wellness.
- { } { } { } { } { } { } 31. Review professional updates to assure relevant data and conclusions are incorporated in program design.
- { } { } { } { } { } { } 32. Assess community needs through systematic data collection methods.
- { } { } { } { } { } { } 33. Plan an evaluation of prevention project through assessment methods.
- { } { } { } { } { } { } 34. Conduct an evaluation of prevention program through assessment methods.
- { } { } { } { } { } { } 35. Coordinate development of appropriate prevention plan with consumer participation.

B. SUPERVISOR'S STATEMENT

Where did you receive your training in prevention?

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 supervisory aspects (i.e., supervision of prevention staff)
- c) Yes, limited to administrative responsibilities such as budgeting.
- d) Yes, both supervisory and administratively

For what period of time, have you provided prevention 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, to the best of my knowledge, all of the above information is true.

Signature Agency Title Date

**DO NOT RETURN THIS FORM TO APPLICANT - PLEASE RETURN TO:
RIBCCDP, 31 Smith Ave -3 Rear Greenville, RI 02828**

**PLEASE SUBMIT A COPY OF YOUR CREDENTIALS; I.E., DEGREE,
LICENSE, ETC. TO THE RIBCCDP ALONG WITH THIS FORM.**

PERFORMANCE DOMAIN SUPERVISION DOCUMENTATION

PLANNING & EVALUATION

- Use needs assessment strategies to gather relevant data for ATOD prevention planning.
- Identify gaps and prioritize needs based on the assessment of community conditions
- Select prevention strategies, programs, and best practices to meet the identified needs of the community
- Develop an ATOD prevention plan based on research and theory that addresses community needs and desired outcomes
- Identify resources to sustain prevention activities
- Identify appropriate ATOD prevention program evaluation strategies
- Conduct evaluation activities to document program implementation and effectiveness
- Use evaluation findings to determine whether and how to adapt ATOD prevention strategies

Hours Supervised

Supervisor Signature

EDUCATION AND SKILL DEVELOPMENT

- Develop ATOD prevention education and skill development activities based on target audience analysis
- Connect prevention theory and practice to implement effective prevention education and skill development activities
- Maintain program fidelity when implementing evidence-based programs
- Assure that ATOD education and skill activities are appropriate to the culture of the community being served
- Use appropriate instructional strategies to meet the needs of the target audience
- Ensure all ATOD prevention education and skill development programs provide accurate, relevant, timely, and appropriate content information
- Identify, adapt, or develop instructor and participant materials for use when implementing ATOD prevention activities
- Provide professionals in related fields with accurate, relevant, timely, and appropriate ATOD prevention information
- Provide technical assistance to community members and organizations regarding ATOD prevention strategies and best practices.

Hours Supervised

Supervisor Signature

COMMUNITY ORGANIZATION

- Identify the community's demographic characteristics and core values
- Identify key community leaders to ensure diverse representation in ATOD prevention programming activities
- Build community ownership of ATOD prevention programs by collaborating with key community leaders/members when planning, implementing and evaluating prevention activities
- Provide technical assistance to community members/leaders in implementing ATOD prevention activities
- Develop capacity within the community by recruiting, training and mentoring ATOD prevention-focused volunteers
- Assist in creating and sustaining community-based coalitions

Hours Supervised

Supervisor Signature

TOTAL HOURS

PERFORMANCE DOMAIN SUPERVISION DOCUMENTATION

CORE FUNCTIONS

PUBLIC POLICY and ENVIRONMENTAL CHANGE

- Examine the community’s public policies and norms to determine environmental change needs
- Make recommendations to policy makers/stakeholders that will positively influence the community’s public policies and norms
- Provide technical assistance, training, and consultation that promote environmental change
- Participate in public policy development and enforcement initiatives to affect environmental changes
- Use media strategies to enhance prevention efforts in the community

Hours Supervised

Supervisor Signature

PROFESSIONAL GROWTH & RESPONSIBILITY

- Maintain personal knowledge, skills, and abilities related to current ATOD prevention theory and practice
- Network with others to develop personal and professional relationships
- Adhere to all legal, professional, and ethical standards
- Build skills necessary for effectively working within the cultural context of the community
- Demonstrate self-care consistent with ATOD prevention messages

Hours Supervised

Supervisor Signature

TOTAL HOURS

Supervisor's Signature

Title

Date signed

Prevention Specialist Reference Form

TO: _____

FROM: _____ DATE: _____

I am in the process of applying for certification as a Certified Prevention Specialist in the State of Rhode Island.

As someone who has been in a position to observe my work in the area of Substance Abuse Prevention, I am requesting that you assist me by completing the enclosed form (s).

My application will not be reviewed until my professional references are received; therefore, your prompt response would be most appreciated.

If you are unable to complete this reference, please return it to me as soon as possible. Otherwise, please mail it directly to:

**Rhode Island Board for the Certification of
Chemical Dependency Professionals
31 Smith Avenue -3 Rear
Greenville, RI 02828**

Sincere Thanks.

I am applying for:

- _____ Level I **Certified Prevention Specialist**
- _____ Level II **Advanced Certified Prevention Specialist**
- _____ Level III **Certified Prevention Specialist Supervisor**
- _____ Any Level **Integrated HIV/AIDS & Viral Hepatitis Specialty**

Applicant: Please Photocopy as needed.

PROFESSIONAL REFERENCE FORM

Applicant's Name _____

Rating: 5) Excellent 4) Good 3) Acceptable 2) Needing Improvement 1) Unacceptable NO) Not Observed

Attribute or Skill:

Exhibits knowledge of chemical dependency _____

Exhibits knowledge of human development _____

Exhibits knowledge of basic helping skills _____

Exhibits knowledge of prevention modalities & strategies _____

Exhibits knowledge of special needs & high risk population _____

Exhibits knowledge of health promotion & wellness models _____

Exhibits skill in developing prevention programs _____

Exhibits skill in delivering prevention programs _____

Exhibits skill in assessing community needs _____

Exhibits skill in writing, utilizing various formats _____

Exhibits ability to work cooperatively with colleagues _____

Exhibits ability to maintain professional objectivity _____

Exhibits ability to exercise initiative _____

Exhibits ability to network effectively with other agencies _____

Exhibits ability to interact with genuineness and respect _____

Exhibits ability to utilize skills such as active

listening, summarizing, reflecting _____

Exhibits ability to engage in productive problem solving _____

Exhibits responsibility with regard to work commitments _____

Exhibits responsibility with regard to ethical conduct

and personal integrity _____

Exhibits responsibility with regard to making appropriate

referrals _____

Exhibits responsibility with regard to agency and federal
confidentiality guidelines _____

PHOTOCOPY AS NEEDED

GENERAL REMARKS:

Person Completing Reference:

Your Name: _____

Address: _____

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 3 TO QUALIFY FOR CERTIFICATION.

PLEASE RETURN THIS FORM TO:

**Rhode Island Board for the Certification of
Chemical Dependency Professionals
31 Smith Avenue -3 Rear
Greenville, RI 02828**

PHOTOCOPY AS NEEDED

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

**PROGRAM DIRECTOR/BOARD CHAIRPERSON
EXPERIENCE VERIFICATION FORM**

I _____ herein certify that
_____ has been employed
as a prevention specialist **, at _____
for _____ hours*, from _____ to _____ .

This program is licensed/accredited/recognized by (eg: DOH, DMHRH, DOE)
as a _____

effective as of _____ .
Date

Signature Title

Date

*hours must be documented cumulatively(total of hours worked)
**describes a principle job function. Principal function must be prevention specialist.

PLEASE PHOTOCOPY AS NEEDED

**ATTACH OFFICIAL JOB DESCRIPTION FROM FACILITIES WHERE
EXPERIENCE IS SUBMITTED FOR CREDIT**

**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 Chemical Dependency Professionals
Counselors In Training
Provisional Certified Chemical Dependency Professionals
Advanced Chemical Dependency Professionals
Advanced Chemical Dependency Professionals II
Chemical Dependency Clinical Supervisor
Recognized Clinical Supervisors
Student Assistance Counselors
Prevention Specialists
Co-Occurring Disorder Professionals
Criminal Justice 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: _____

RECERTIFICATION REQUIREMENTS

PURPOSE OF CONTINUING EDUCATION

The purpose of continuing education is ongoing professional development. This benefits the Consumer and provider. It is understood that professionals will build upon their previously demonstrated (in the portfolio and exam) competencies, and will demonstrate their professional development in pursuit of continuing education. Applicants will be notified of deadline for submission of continuing education upon certificate award and three (3) months prior to deadline along with recertification manual.

DEFINITIONS

One (1) hour credit for each clock hour spent in workshops, etc.

One (1) approved college or university semester credit will be equal vent to fifteen clock hours.

One (1) approved college or university quarter credit will be equal vent to ten (10) clock hours.

LIMITATIONS

1. Clock hours must be obtained within the time limitations of: Date of submission of initial application or recertification application until 60 days prior to expiration of certification. These hours are not cumulative.
Example: Extra earned units may not be applied to a future certification.
2. Certified professionals must obtain 40 clock hours every two years in order to be eligible for recertification. It is strongly recommended, but not required, that counselors obtain twenty clock hours per year.
3. Of these 40 clock hours, a minimum of 30 shall be in Category I (Substance Abuse Specific), Source A/B/C/D/E. **6 Hours Best Practice Required (i.e., Methadone Training, Co-Occurring Disorders, Hep C & HIV, PTSD, Domestic Violence, New Drugs, Prescription Drugs, Compulsive Gambling, CSAP Model Programming, Environmental Strategies and Suicide Assessment).**
4. Up to 10 clock hours, which are not Substance Abuse Specific, may be included under Category II.
5. All Certified Prevention Specialist with Specialty in HIV/AIDS & Viral Hepatitis are required to successfully complete **18 Hours Integrated HIV/AIDS & Viral Hepatitis Counseling, Testing & Referral (approved by DOH – Project REACH) every five (5) years**

Breakdown of Recertification Requirements:

CATEGORY I. – Substance Abuse Specific- 30 hours minimum- Source A,B,C,D,E

CATEGORY II. - Professional Training - 10 hours maximum - Source A ONLY

Source A – Courses, Workshops, Seminars - (Unlimited hours)

Source B – Presenter/Lecturer/Teacher - (30 Hours Maximum)

Source C – Independent Study - (30 Hours Maximum)

Source D – Professional Community Involvement - (10 Hours Maximum)

Source E – Research Paper/Professional Publication - (30 Hours maximum)

***Required –6 Hours Best Practice (i.e., Methadone training, Co-Occurring Disorders, Hep C & HIV, PTSD, Domestic Violence, New Drugs, Prescription Drugs, Compulsive Gambling, CSAP Model Programming, Environmental Strategies and Suicide Assessment)**

**** All Certified Prevention Specialist with Specialty in HIV/AIDS & Viral Hepatitis are required to successfully complete 18 Hours Integrated HIV/AIDS & Viral Hepatitis Counseling, Testing & Referral (approved by DOH – Project REACH) every five (5) years**

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 Americans with Disabilities Act of 1990 (ADA) as they pertain to the RIBCCDP's credentialing and certification 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 will 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 when 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.

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

(Name and Address of Health Care Provider)

to 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