

ACDP II Application

Advanced Chemical Dependency
Professional II

DIRECTIONS/CHECKLIST

- Official transcript required sent directly from college/university to the RIBCCDP Office.
- Certificates of attendance for trainings.
- All required documentation to support employment (i.e. letters from former employers verifying employment, current job description, signed and dated by applicant and supervisor).
- Sign and date the Code of Ethical Conduct.
- Supervision form completed and signed by supervisor.
- Fee of \$250. May be paid by check/money order (payable to RIBCCDP) or with PayPal (by visiting www.ribccdp.com and clicking on Pay Fees. If paying through PayPal, fee must be paid prior to submission of application.

Applications will be open for one year. If all requirements are not met within one year, the application will expire and the applicant will be required to resubmit a new application and fee.

If you have other credentials with RIBCCDP, please call the office before applying.

If there are any problems with the application, you will be notified by email or phone.

Keep a photocopy of the entire application. Send your completed application, copies of certificates of attendance, attachments, and fee to:

RIBCCDP
298 S. Progress Avenue
Harrisburg, PA 17109
Phone: (717) 540-4456 Fax: (717) 540-4458
Website: www.ribccdp.com Email: info@ribccdp.com

REQUIREMENTS FOR ACDP II

Employment

- One year (2000 hours) of paid or volunteer work experience as an alcohol and drug counselor or supervisor of same. Employment must have been gained within the last five years.
- Volunteer and part-time counseling experience is acceptable if it is provided under direct supervision. Actual time spent in a supervised substance abuse internship, or practicum may be applied toward the employment requirement.
- Supervised work experience must be in the ten ADC domains.
- Applicant must be currently employed in an alcohol and drug counseling position at the time application is submitted.
- Acceptable employment is based on applicant providing direct, primary alcohol and drug counseling to persons whose primary diagnosis is that of alcohol and/or drug addiction or that applicant is providing supervision of addiction counseling.
- Applicant must have primary responsibility for providing counseling in an individual and/or group setting, preparing treatment plans, documenting client progress and is clinically supervised by an individual who is knowledgeable in addiction.

Supervision

- 300 hours with a minimum of 20 hours in each domain.
- The individual providing the supervision must be one of the following:
 - Certified/licensed as a CDCS or LCDS.
 - Have a Master's degree in the behavioral science field with two years clinical experience and 120 hours substance abuse training, including 30 hours of clinical supervisor training.
 - ACDP, ACDP II, or LCDP with 30 hours of clinical supervisor training.
 - Ph.D. in the behavioral science field or M.D. with documentation of two years of specialization/experience in the substance abuse field.
 - RCS.

Education

- Master's degree from an accredited college or university that is recognized by the US Department of Education or the Council on Higher Education Accreditation. An official transcript sent directly from college/university is required.
- 180 hours of substance abuse specific education, of which 12 hours are in confidentiality, six hours in chemical dependency counselor ethics, six hours in communicable diseases and 12 hours in medication assisted treatment and attitudes of medication in the recovery process.
- Education is defined as formal, structured instruction in the form of workshops, seminars, institutes, in-services, college/university credit courses and RIBCCDP approved distance education.
- Education must be specifically related to the knowledge and skills necessary to perform the tasks within the ten domains.
- Three college credits are equivalent to 45 hours.
- Education, as defined above, applicant provides to others may also be used providing it is verified in writing by sponsoring school or agency.

Examination

- Pass the IC&RC Examination for Advanced Alcohol and Drug Counselors.

Other

- Signed and dated Code of Ethical Conduct.
- Signed, dated and witnessed Release.
- Current job description dated and signed by supervisor and applicant.
- Applicant must either live or work in RI at time of application.

Domains

1. Clinical Evaluation
2. Treatment Planning
3. Referral
4. Service Coordination
5. Counseling
6. Client, Family & Community Education
7. Documentation
8. Professional & Ethical Responsibilities
9. Research Design, Analysis & Utilization
10. Clinical Supervision.

Fees

Certification:	\$250
Retest:	\$150
Exam Cancellation:	\$150

(fee must accompany application and materials)

CERTIFICATION TIME PERIOD

RIBCCDP certification encompasses two calendar years commencing on the date of passing of the exam. Two dates, date of issue and valid through, will appear on the certificate along with a certification number.

APPEAL PROCESS

The purpose of appeal is to determine if RIBCCDP accurately, adequately and fairly reviewed applicant's file. A letter requesting an appeal must be made to RIBCCDP in writing within 30 days of the notification of the board's action. A person shall be considered notified three days after the relevant date of mailing. The written appeal will be sent to the Executive Committee who in turn will thoroughly review the entire application and materials to determine whether or not applicant should have been denied approval. Applicant will be notified in writing as to the findings of the Executive Committee.

EXAMINATION INFORMATION

Type: This credential requires successful completion of the IC&RC exam which is offered as a computer based exam. Four hours are permitted to complete the 175 question, multiple choice exam. Candidates will be notified by RIBCCDP, once application for certification is approved, on how to register for the computer based exam.

Content: The IC&RC Job Task Analysis for this credential identified domains which make up the questions in the exam. Within each domain are several identified tasks that provide the basis for questions in the exam.

Candidate Guide: The domains, including the knowledge and skill areas of each domain, sample exam questions, and a list of references are included in the free Candidate Guide. Candidate Guides will be sent to candidates prior to exam scheduling. Candidate Guides are also available from the RIBCCDP website at www.ribccdp.com by clicking on "Testing."

Study Guides: Professional study guides have been published for several of the exams including ADC, AADC, CCS, CCJP, CCDP and CPS. Study Guides are available for sale from DLCAS at www.ReadyToTest.com.

Dates: The IC&RC exam is offered on demand at approved testing centers thereby allowing candidates to test on a date and time convenient for them. Candidates will receive information from RIBCCDP on registering for on demand testing once application for certification is approved.

Locations: There are four computer based testing sites in Rhode Island – one in the Lincoln area, one in the Providence area, and one in the Newport area and one in the Warwick area. Candidates can choose the testing site that is closest for their travel.

Special Situations: Individuals with disabilities and/or religious obligations that require modifications in exam administration may request specific procedure changes, in writing, to RIBCCDP no fewer than 60 days prior to the scheduled exam date. With the written request, candidate must provide official documentation of the disability or religious issue. Contact RIBCCDP on what constitutes official documentation. RIBCCDP will make arrangements for appropriate modifications to its procedures when documentation supports this need.

Cancellation/Rescheduling Policy: Candidates are required to arrive on time for their exam. Candidates who arrive late will not be permitted to test and will be charged a \$150.00 cancellation/rescheduling fee. Candidates who cancel or reschedule their exam less than five days prior to their scheduled date will be charged the full testing fee. Candidates who cancel or reschedule more than five days before their scheduled date will be charged a \$25.00 cancellation/rescheduling fee.

Retest: Candidates failing the exam can retest after a 60 day wait period from date of last taking the exam. Candidates will be sent retest instructions from RIBCCDP.

LICENSING

Applicants who successfully meet all ACDP II requirements are eligible for Licensed Chemical Dependency Professional (LCDP) designation. Candidates must complete the licensing application and submit it directly to the Rhode Island Board for Licensing for Chemical Dependency Professionals (RIBLCDP). Application can be found at: <http://www.health.ri.gov/applications/ChemicalDependencyProfessional.pdf>.

The ACDP II is a mandatory prerequisite for the LCDP.

RECERTIFICATION

To maintain the high standards of this professional practice and to assure continuing awareness of new knowledge in the field, RIBCCDP requires recertification every two years.

To be recertified as an ACDP II, an individual must:

1. Hold a current and valid certificate issued by RIBCCDP;
2. Acquire 40 hours of RIBCCDP approved education, including 30 hours substance abuse specific, and three hours in professional ethics and responsibilities received within the two year recertification cycle;
3. Verify that you have reviewed, read and will uphold by practice the RIBCCDP Code of Ethical Conduct for professional behavior;
4. Complete an application and pay the recertification fee.

LAPSED CERTIFICATION

The completed recertification application should be received at RIBCCDP prior to the expiration date. If the application is incomplete, applicant will be notified by phone or email depending on what has been indicated by applicant.

There is no grace period. If the recertification is not completed by the expiration date, the individual will no longer hold a ACDP II and no further use of the ACDP II is permitted until the individual has recertified.

All certified professionals should review the recertification application well in advance of the expiration date. A Reinstatement Fee is due if the recertification is late between one day and five years. After five years, no recertification is possible and applicant would have to reapply for the credential, meeting all current requirements.

INTERNATIONAL CERTIFICATION & RECIPROCITY CONSORTIUM (IC&RC)

The purpose of the IC&RC is:

- to promote uniform professional standards and quality assurance for the alcohol and drug profession and to give the profession greater visibility throughout the United States and other countries;
- to negotiate reciprocity agreements for alcohol and drug professionals with certification bodies throughout the United States and other countries;
- to provide support services, including consultation and training to all states in all areas of certification, such as establishment of standards, evaluation of competence, establishment and training of boards and committees;
- to provide information on certification and certification activities throughout the United States and other countries;
- to provide an International Certificate (ICAADC) for counselors meeting specified qualifications certified by individual IC&RC member certification boards. Any IC&RC certified alcohol and drug counselor is eligible. ICAADC certificates are provided free of charge from IC&RC;
- to promote uniform professional standards in AADC specialty disciplines.

Certified professionals in the state of Rhode Island have reciprocity with many certifying bodies throughout the United States and other countries as well as all of the armed services. For reciprocity process and/or a listing of member boards, please call the RIBCCDP Office.

APPLICATION FOR ACDP II

Form can be completed and saved. You may then print the appropriate pages to submit to RIBCCDP.

Other past or current RIBCCDP credentials held: SAC PCDP ACDP CCJP RCS CDCS PCCDP CCDP
 CCDPD APS CPS ACPS CPSS

Date: _____ Date of Birth: _____ Male Female

Name: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

County: _____ Home Phone: _____ Email: _____
(required)

Position/Title: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

County: _____ Work Phone: _____ Ext: _____

Dates Employed: _____ Hours per Week: _____

Immediate Supervisor: _____ Title: _____

Phone: _____ Email: _____

College/University: _____ Name on Transcript: _____

If RIBCCDP needs to contact you, please indicate your preference: Email Phone

Why are you pursuing certification? *required* _____

I hereby attest that the applicant is working in a position where a minimum of 51% of his/her time is spent providing direct, primary alcohol and drug counseling OR that the applicant is working in a position where a minimum of 51% of his/her time is spent providing supervision of counseling.

The applicant has primary responsibility for providing or supervising alcohol and drug counseling in individual and/or group settings, preparing treatment plans, documenting client progress and is clinically supervised by an individual who is knowledgeable in addiction.

Supervisor's Signature

Have you ever received any disciplinary action from another certification or licensing authority? Yes No
If yes, please explain in full on a separate sheet.

Have you ever been convicted of a felony violation in any state or federal law? Yes No
If yes, please explain in full on a separate sheet.

Have you ever been licensed/certified in any other state? Yes No
If yes, please explain in full on a separate sheet.

Fee of \$250 can be paid using one of the following:

Check/MO (payable to RIBCCDP) PayPal – go to www.ribccdp.com and click on Fees.

Please print your name as it should appear on your certificate:

PREVIOUS EMPLOYMENT, IF APPLICABLE

Include letter (on company letterhead) from previous employer verifying your duties and dates employed.

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Your Title: _____ Hours per Week: _____

Dates Employed: _____ Immediate Supervisor: _____

Primary Responsibilities: _____

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Your Title: _____ Hours per Week: _____

Dates Employed: _____ Immediate Supervisor: _____

Primary Responsibilities: _____

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Your Title: _____ Hours per Week: _____

Dates Employed: _____ Immediate Supervisor: _____

Primary Responsibilities: _____

SUPERVISION

To Supervisor: Please complete this form indicating applicant's on-the-job supervision. This form is not intended to document applicant's total number of hours worked but rather the hours of on-the-job supervision you have provided the applicant. Supervision is a formal or informal process that is administrative, evaluative, clinical, and supportive. It can be provided by more than one person, it ensures quality of clinical care, and extends over time. Supervision includes observation, mentoring, coaching, evaluating, inspiring, and creating an atmosphere that promotes self-motivation, learning, and professional development. In all aspects of the supervision process, ethical and diversity issues must be in the forefront.

Applicant's Name: _____

I hereby attest that a minimum of 300 hours of supervision in the domains have been attained by the above-named applicant. At least 20 hours in each of the domains were received as outlined below.

AADC DOMAINS

OF HOURS RECEIVED IN EACH

1. Clinical Evaluation	_____
2. Treatment Planning	_____
3. Referral	_____
4. Service Coordination	_____
5. Counseling	_____
6. Client, Family and Community Education	_____
7. Documentation	_____
8. Professional and Ethical Responsibilities	_____
9. Research Design, Analysis & Utilization	_____
10. Clinical Supervision	_____
TOTAL MUST BE AT LEAST 300 HOURS	_____

Supervisor's Signature

Date

CLINICAL SUPERVISOR'S EVALUATION INFORMATION

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

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

PROFESSIONAL REFERENCES

I have requested the following individuals to forward their recommendations to RIBCCDP. List three people, other than your supervisors who know you professionally and can attest to your professional skills.

Name of Employer: _____

Phone: _____ Email: _____

Name of Employer: _____

Phone: _____ Email: _____

Name of Employer: _____

Phone: _____ Email: _____

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.

Photocopy all forms as needed.

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 Professional (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

Have you ever had any action taken against your certification/license?

Yes No

If the answer is Yes, please provide details on a separate sheet.

Have you even been disciplined in any way by a certification/licensing board or professional organization?

Yes No

If the answer is Yes, please provide details on a separate sheet.

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 statement or omissions shall result in the denial or revocation of my certification/license or renewal of my 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, RIBLCDP, 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, RIBLCDP 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, RIBLCDP, and RIDOH its members, officers, employees and examiner's harmless and free from all liability from complaints, causes of actions, suits, claims, demands and damages of every nature or kind pertaining or arising out of or relation in any manner whatsoever to actions taken by RIBCCDP, RIBLCDP and RIDOH in investigating my application and making a determination regarding my certification.

I further authorize RIBCCDP, RIBLCDP, 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, International Certification & Reciprocity Consortium (IC&RC) and the RIBLCDP. 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.

Name: _____ Signature: _____

Witness: _____ Signature: _____

CLINICAL SUPERVISOR'S EVALUATION FORM

CONFIDENTIAL

Dear Clinical Supervisor:

Your employee named on the accompanying form is applying to RIBCCDP for certification as a Advanced Chemical Dependency Professional II. The information requested here is an essential part of RIBCCDP's evaluation of the competence of the applicant and must be on file before the application can be processed.

Requirements for Clinical Supervisors:

- Certified/licensed as a CDCS or LCDS.
- Have a Master's degree in the behavioral science field with two years clinical experience and 120 hours substance abuse training, including 30 hours of clinical supervisor training.
- ACDP, ACDP II, or LCDP with 30 hours of clinical supervisor training.
- Ph.D. in the behavioral science field or M.D. with documentation of two years of specialization/experience in the substance abuse field.
- 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 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 RIBCCDP reserves the right to request further information from you concerning this applicant. Your cooperation will be very much appreciated in this effort.

Please return the completed evaluation along with documentation of the above clinical supervisor requirements.

Sincerely,

RIBCCDP

CLINICAL SUPERVISOR'S EVALUATION FORM

Applicant Name: _____ Date: _____

Clinical Supervisor: _____ Credentials: _____

Phone: _____ Email: _____

The following items represent the skills needed by an ACDP. 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. Applicants must earn an average of four on the rating scale to qualify for this certification.

RATING SCALE:

- 1 is NOT APPLICABLE
- 2 is DON'T KNOW
- 3 is POOR
- 4 is AVERAGE
- 5 is ABOVE AVERAGE
- 6 is SUPERIOR

- ____ 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.
- ____ 6. Counseling (individual, group and significant others) – the utilization of special skills to assist individuals, families or groups in achieving objectives through:
 - Exploration of problem and its ramifications
 - Examination of attitudes and feelings;
 - Consideration of alternative solutions, and;
 - Decision making.
- ____ 7. Case Management – activities which bring services, agencies, resources of people together within a planned framework of action towards 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 and Recordkeeping – charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries and other client-related data.
- ___ 12. Consultation – relation 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.

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

- ___ 1. Respect for the client.
- ___ 2. Concern for the client.
- ___ 3. Genuineness with the client.
- ___ 4. Empathy with the client.
- ___ 5. Flexibility with the client.
- ___ 6. Judgment with the client.
- ___ 7. Spontaneity with the client.
- ___ 8. Capacity for confrontation with the client.
- ___ 9. Capacity for appropriate self-disclosure.
- ___ 10. Sense of immediacy.
- ___ 11. Ability to set appropriate boundaries.

Evaluators Statement

Where did you receive your training? _____

How long have you been employed by this program? _____

Professional certificates/licenses you hold: _____

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

- ___ No
- ___ Yes, limited to clinical aspects (i.e. supervision of counselors)
- ___ Yes, limited to administrative responsibilities such as budgeting
- ___ Yes, both clinically and administratively

What is/was the overall size of applicants substance abuse caseload? _____

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

Average number of hours per week 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?
(Please 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? _____

Comments or additional information (optional):

I hereby certify that I have been in a position to observe and have firsthand knowledge of the applicant’s work and that all of the material is, to the best of my knowledge, true.

- I recommend this applicant for certification.
- I have some reservations in recommending this applicant.
- I do not recommend this applicant.

Signature: _____ Agency: _____

Title: _____ Date: _____

Please submit documentation of Clinical Supervisor requirements as noted on RIBCCDP’s standards or a copy of your RCS certification. Do not return this form to the applicant – please return to RIBCCDP.

PROFESSIONAL REFERENCE FORM

Dear: _____

I am applying to the RIBCCDP for certification. References must be included as part of the application. Please complete the reference material enclosed and return it to RIBCCDP. Your prompt attention to this would be very much appreciated, as my application will not be processed until RIBCCDP 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 the 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 RIBCCDP. Your cooperation will be very much appreciated.

Sincerely,

RIBCCDP

Applicant name: _____

The following areas represent skills and knowledge needed by a 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.

RATING SCALE:

- 1 is NOT APPLICABLE
- 2 is DON'T KNOW
- 3 is POOR
- 4 is AVERAGE
- 5 is ABOVE AVERAGE
- 6 is SUPERIOR

- ____ 1. Common sense in dealing with the client
- ____ 2. Respect for the client
- ____ 3. Empathy for the client
- ____ 4. Care and concern for the client
- ____ 5. Flexibility with the client
- ____ 6. Spontaneity with the client
- ____ 7. Capacity for confrontation with the 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 the client
- ___ 14. Problem recognition and evaluation: ability to apply knowledge of physical, behavioral, attitudinal and effective manifestations of substance abuse to determine its existences 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 client

General Remarks (optional):

Your name: _____

Email: _____ Telephone: _____

Position: _____

How long have you known the applicant? _____

My relationship with him/her is/was? _____

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 return this form to RIBCCDP.

CODE OF ETHICS AND DISCIPLINARY PROCEDURES

The entire Code of Ethics can be found on our website at www.ribccdp.com or may be obtained from the office by calling 717-540-4456.

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

I do accept all of the principles of RIBCCDP's Code of Ethics and Disciplinary Procedures as prescribed by RIBCCDP.

Signature: _____ Date: _____